

**Developing and integrating cultural competence into nursing education curricula: a  
qualitative grounded theory approach**

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## **ABSTRACT**

The changing demographic UK population in terms of cultural, racial and ethnic mix demands mental health nurses to be educated in ways that will enable them to provide care that is both efficient and culturally appropriate to the diverse population they will serve. However, reported studies indicate that professional nurses, particularly mental health nurses, are not ready to meet the challenges posed by an increasingly culturally diverse society. These have raised questions about the undergraduate nursing education's readiness to develop a mental health work force that is capable of delivering effective mental health services to a multicultural population.

The aim of the study was to explore and gain an understanding of cultural competence education from the perspectives of the key participants involved in the undergraduate mental health nursing education within the UK context, and to use the findings to develop a conceptual framework of developing cultural competence. Qualitative grounded theory approach was the method of inquiry used to collect and analyse interview data from the experiences and views of senior lecturers, third year mental health student nurses, clinical sign-off mentors and student mentors within the universities that offer pre-registration mental health nurse training in the West Midlands Region.

Analysis of the research findings resulted in an emergent conceptual framework that explains how cultural competence is developed in the undergraduate mental health nursing curriculum in terms of content, processes, strategies, actions and approaches that are considered effective. The findings of this study revealed a degree of consistency between the views of the current study participants and what the literature describes as frameworks for developing cultural competence. The main theoretical constructs emerging from the study fit into a cultural competence frameworks encompassing awareness, knowledge and skills.

Whilst some of the themes and theoretical constructs emerging from the results of the interview data were generally consistent with those indicated in the cultural competence literature, there were some other themes that emerged from the study participants on what was required within the curriculum in order to educate student nurses in ways that will enable them to work effectively and culturally appropriately with clients from diverse cultural backgrounds. The additional bridging theoretical construct included 'conscious of the dynamics and discourse of

intercultural education’ which was a result of the differing ideological views about current curricula and how issues of cultural competence could best be addressed within the curricula. The strategies of ‘engagement of local experts to assist in teaching cultural competence specific areas’ and ‘creating educational activities that challenge stereotypes, prejudice, discrimination and religious intolerance’ also expands the current literature by providing evidence to support some of the conceptualisations regarding some of the educational intervention strategies to cultural competence.

This study is significant as it represents the first attempt to develop a conceptual framework of developing cultural competence within the UK context based on the perspectives of those directly experiencing the undergraduate mental health nursing education, using qualitative grounded theory approaches. Exploring and developing the conceptual framework from the perspectives of the neglected silent voices of the key participants who are directly involved in the undergraduate nurse training within the UK context, contributes to the existing research in this area and provides a view not currently presented in the nursing literature.

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### **Key of the abbreviations used in this thesis:**

SL = Senior Lecturer,

SN = Student Nurse,

SFG = Student Nurse on Focus Group

CM = Clinical Mentor

CSM = Clinical Sign-off Mentor

## **Chapter 1: INTRODUCTION AND BACKGROUND**

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## Chapter 1: Introduction and background

### 1:0: Definitions of terms used in this study

**Black and minority ethnic (BME)** - For the purpose of this study, borrowing from the *Delivering Race Equality in Mental Health Care (DRE)* document, the term 'Black and minority ethnic' (BME) is used to refer to all people of minority ethnic status in the United Kingdom. It does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants (DOH, 2005, p11).

**Cultural Competence** – as coined and synthesized in Section 2.3.2 of this study, 'cultural competence' is defined here as *a learnt or developed skill that enables the healthcare practitioner to serve and interact appropriately, effectively and competently with people from diverse cultural backgrounds.*

Likewise, 'cultural competence education' is defined here *as a process of developing the health care practitioner in order for the health care practitioner to have the capacity and enthusiasm to continuously develop self, in order to be able to respond and provide effective health care that is congruent to people's cultural needs.*

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## **1:1: Population diversity in the UK and impact on mental health care services and practitioners**

The United Kingdom (UK) is a multicultural society. The recent figures from the Office for National Statistics (ONS) show that the population of the UK is diversifying rapidly in terms of cultural, racial and ethnic mix (ONS, 2011). According to the data release from the ONS, the total UK population was recorded as about 62.3 million and that the 'Black and minority ethnic' (BME) population has grown from 6.6m in 2001 to 9.1m in 2009 (ONS, 2011). These figures indicate that nearly one in six people of the population is from BME. The same data points out that the White British population has stayed the same since the 2001 census. This is due to the fact that whilst there has been an increase in births, there have also been a similar number of people migrating (ONS, 2011). The ONS figures show that the BME population of the UK is concentrated in the large urban centres and in some cities such as Bradford, the 'Black and minority ethnic' people are numerically the majority (ONS, 2011).

The changing composition of UK society presents challenges in terms of providing mental healthcare services which are responsive to the needs of an increasingly multicultural population. The links between discrimination, disadvantage and poor mental health for some cultural and social groups are well documented and more evident particularly in the area of mental health care and mental health services (NIMHE, 2003; DOH, 2005, Cotton, 2012). In terms of access to services, experience of care, and other measures of outcomes relating to mental health care, it is claimed that 'historically some cultural and social groups have fared less well' (Cotton, 2012, p.9). This could be evidenced by the rates of admission and detention to mental health services. For example, according to the recent figures of the Care Quality Commission report, the rates of admission and detention to inpatient mental health units in UK continue to be higher for 'Black African', 'Black Caribbean' and 'Black Other' groups than for other population group (Care Quality Commission, 2011).

Kirmayer (2002) pointed out that one of the challenges faced by nurses in an increasing population diversity is the need for nurses to learn to decode the meaning of somatic and dissociative symptoms that are not simply indices of disorder but are part of a language of distress



with cultural and wider social meanings. This could be because the needs of diverse cultures, each with unique values and practices can be overwhelming for nurses and other health care professionals to contemplate. This may result in practitioners unnecessarily admitting and detaining the clients from those cultural backgrounds they may have difficulties in understanding or equating with their own. That could be one of the reasons why Leininger and McFarland (2002) warned that the increasing diversification of a society would require health care providers and practitioners to act and think with the global perspective so that they understand the importance that culture plays in peoples' perceptions of their health needs and in their responses to the health care services they receive.

Additionally, the increasing UK population diversity not only poses challenges to the mental health care services, but also to the mental health care practitioners in terms of considering the diverse clients cultural needs (Gerrish and Papadopoulos, 1999; Salimbene, 1999; Leininger and McFarland 2002; Leishman, 2004; Sealey et al., 2006). For example, with increasing population diversity, health care practitioners such as mental health nurses are more likely than ever before to encounter individuals from diverse cultural, racial and ethnic backgrounds in their practice. As a result, changes in the cultural composition of a population means that health care practitioners are now expected to provide health care services for groups in that society that are culturally, racially and ethnically different from those with which the health care practitioners are familiar. This also means 'health care services that are designed to cater for relatively mono-cultural populations' will be 'required to review their ability to meet the needs of different ethnic groups' (Papadopoulos et al, 2004, p. 108)

As a result of increasing population diversity, there is growing evidence to suggest that the mental health care systems across the UK are inadequately addressing the care needs of Black and minority patients as compared to the majority White populations (Serrant-Green, 2001: Department of Health, 2001; NIMHE, 2003; Narayanasamy, 2003; DOH, 2005). Furthermore, concerns have been raised suggesting that the healthcare delivery system in UK is largely uni-cultural and ethnocentric in approach, whereby primacy is given to the majority white population and only peripheral recognition is given to the presence of other Black and ethnic groups (The Sainsbury Centre for Mental Health, 2002; Sue, 2004).

As the UK population continues to diversify, there is a pressing need for mental health nurses to develop the ability to work effectively with and relate to others from diverse cultural backgrounds (DOH, 2005; Cotton, 2012). This need has been highlighted in research documents and Government policies such as the *National Service Framework for Mental Health* (DOH, 1999), *Inside Outside* (NIMHE, 2003) David Bennett Inquiry (DOH, 2005), *Delivering Race Equality in Mental Health Care* (DOH, 2005) amongst others. Specifically, there have been numerous national initiatives, policies, programmes and guidance aimed at developing a mental health work force that is capable of delivering effective mental health services to a multicultural population (NMC, 2002; NIMHE, 2003; DOH, 1999; 2005; QAA, 2009).

There is also a growing literature that highlights the problems that people from Black and minority backgrounds face in terms of accessing and experiencing appropriate mental healthcare services in UK (DOH, 2005, DHMHPD and NMH DU, 2009; Cotton, 2012). In particular, it is claimed that the mainstream services may not be responsive to the needs of people from different cultural backgrounds as ‘different ethnic groups may have varied perceptions about mental health services and may want to access and use them in different ways’ (DHMHPD and NMH DU, 2009, p.6). There is also evidence to suggest that nurses, alongside other healthcare professionals, lack the necessary knowledge and skills to respond to the needs of people from a different cultural background to their own (Serrant-Green 2001; Hildenberg and Schlickau, 2002). Serrant-Green (2001) suggested that limited understanding of how cultural diversity within and between different migrant communities may affect health beliefs and behaviours as well as healthcare preferences may imply that nurses treat all patients according to the norms of the dominant cultural group. This may result in patients from Black and ethnic minority groups being devalued compared to their White counterparts. The above issues identify the need for mental health nurses to be educated in ways that will enable them to provide care that is both effective and cultural appropriate to the diverse populations that they will serve. This also requires the need to develop the necessary knowledge, skills and attitudes for nurses to practice within a multicultural society.

## **1.2: Challenges of nurse education programmes due to increasingly population diversity**

While health care providers are required to scrutinize the way in which their services are rendered, training providers such as universities are required also to re-examine their own roles in preparing students for entry into those service professions (Brennan and Cotter, 2008; ENB, 1997; NMC, 2002; QAA, 2009). Specifically, training providers are charged with the responsibility of educating nurses 'in ways that will enable them to provide care that is both efficient and culturally appropriate', (Papadopoulos, 2006, p. 8). This education is a way is to ensure a culturally competent practice by developing 'a mental health work force that is capable of delivering effective mental health services to a multicultural population' (NIMHE, 2003, p. 19). This is because 'culturally competence care is becoming a twenty first century imperative for those responsible for providing health care services in multicultural societies' (Papadopoulos, 2006, p. 22).

Additionally, as the world becomes more culturally and ethnically diverse, reported studies indicate that nursing students as well as professional nurses are not ready to meet the challenges posed by an increasingly culturally diverse society (Hildenberg and Schlickau, 2002; Leishman, 2004; Leininger, 1994; Leininger and McFarland, 2006; Miller et al., 2008; Pacquiao, 2008; Koskinen et al, 2009). In particular, Leininger previously raised questions on whether nurses are prepared to provide cultural competent care through their formal courses or programs of study in an editorial titled 'Are Nurses Prepared to Function Worldwide?' (Leininger, 1994, p. 2). Other literature questions the undergraduate nursing education's readiness to develop a mental health workforce that is capable of delivering effective mental health services to a multicultural population (NIMHE, 2003; NSCSHA, 2003; DOH, 2005; Centre for Mental Health et al, 2012).

A United States of America (USA) national survey that examined how schools of nursing were addressing cultural competence in their programs concluded that 'although many nursing programs provide content to enable students to become culturally sensitive, they do not provide the extra step to ensure that their students are capable of practising nursing in a culturally competent manner' (Rodriguez 1997, p. 13). In addition, a recent qualitative study of nursing graduates revealed that half felt inadequately prepared to provide culturally competent care, and most were uncomfortable in providing care to patients whose cultural backgrounds were different from their own (Reeves and Fogg, 2006). There are also reports indicating that not all students in the undergraduate nursing programs are receiving adequate content in cultural competence

nursing and that, where it is being received, the content is inconsistent (Hildenberg and Schlickau, 2002; Dogra and Pokra, 2005; Mahoney, 2006). For example, Hildenberg and Schlickau (2002) conducted a collaborative learning activity that was aimed at improving students' transcultural knowledge between two different nursing programs in different geographical locations. Their findings revealed that 'newly qualified nurses lacked the skills and knowledge to successfully deal with clients from diverse cultures' and recommended that the 'nursing programs need to better prepare students in transcultural nursing' (Hildenberg and Schlickau, 2002, p. 241.). Lundberg and colleagues used a questionnaire survey triangulated by semi-structured interviews to explore the Swedish last-year nursing students' experiences of care giving to patients who are culturally diverse (Lundberg et al., 2005). Their study concluded that cultural competence education should be included into the nurse education curriculum (Lundberg et al., 2005). Additionally, Reeves and Fogg (2006) qualitatively explored senior students' perceptions of transcultural nursing and identified common feelings of inadequate cultural knowledge necessary to provide culturally competent care and lack of comfort when providing care to clients different from themselves. These have raised questions about undergraduate nursing education's readiness to prepare culturally competent nursing graduates.

In response, Koskinen and colleagues emphasised that 'nursing education worldwide needs to respond to the challenges of an increasingly more diverse society by developing study programmes that educate culturally competent practitioners' (Koskinen et al 2009, p. 503). As a result, nurse scholars recommend that nurse educators plan their teaching regarding culture from a sound theoretical base in order to adequately prepare students for practice in cross-cultural care (Papadopoulos, 2006; Allen 2010).

The UK's nursing professional bodies (ENB, 1997; NMC, 2002) and UK cultural competent experts (Gerrish and Papadopoulos, 1999; Papadopoulos, 2006) share the same perspective and have identified cultural competence as an instrument with which address diversity issues and 'a core knowledge requirement' when training health care practitioners (Bhui et al., 2007, p.1). More crucially, in UK, demands are being put on nursing faculty to incorporate content related to cultural competence in the undergraduate curriculum (ENB, 1997; NMC, 2002; Papadopoulos, 2006; QAA, 2009). Professor Irena Papadopoulos emphasised that 'nurses must be educated in ways that will enable them to provide care that is both efficient and culturally appropriate', (Papadopoulos, 2006, p.8). Accordingly, there is growing pressure and focus on nurse educators to provide the nursing students with the required skills, knowledge and attitudes to care for an

increasingly diverse population (Papadopoulos, 2006). Universities are charged with the responsibility to prepare student nurses so that they understand how to work with diverse groups of races, cultures and languages that nursing students may or may not represent in the classroom environment (ENB, 1997; NMC, 2002; QAA, 2009). For example, increasing diversity in UK population is also seen student body.

In a diverse student in a classroom environment, every student is a unique cultural individual with unique characteristics and needs. The nursing student's unique needs could influence learning styles, learning experiences, social status and developmental needs (Keengwe, 2010). As a result, it is critical that nurse educators understand how these attributes and respond with skill and sensitivity to help support each nursing student to attain their full potential in order to provide care that is culturally appropriate to the diverse population they will serve. Therefore, establishing sound pedagogy rooted on cultural understanding of the diverse nursing students within the classroom environment is a critical given that racial, cultural, ethnical and social integration has the potential to increase academic success for all learners (Smith, 2004; Keengwe, 2010).

However, some good work is being done in this area. Some literature suggests that the nursing education is making efforts to educate their students in preparation for work with diverse clients. For instance, using Purnell's model for cultural competence (Purnell and Paulanka, 2003) as the organizational framework, Phelps and Johnson (2004) positively demonstrated how a health department rose to the challenge of assisting their health workforce to develop culturally sensitive and appropriate health services to a rapidly increasing population of Haitian immigrants. Some evidence suggests that efforts have been made in the UK mental health workforce to prepare a more culturally competent nursing workforce (Papadopoulos and Lees, 2002; Papadopoulos, 2006).

However, these efforts seem not to be successful as others are questioning the cultural competence of the UK mental health workforce, indicating that that mental health workforce as well as professional mental health nurses are not ready to meet the challenges posed by an increasing culturally diverse UK society (Sainsbury Centre for Mental Health, 2002; NSCSHA, 2003; DOH, 2005; Centre for Mental Health et al, 2012).

Furthermore, although the theoretical constructs of culturally competence have been supported and promoted by the nursing professional organizations (ENB, 1983; NMC, 2001; ICN, 2003; QAA, 2009), and a large proportion of nurse training programs include cultural competence in their curriculum, evidence exists that it is not well taught and the impact is unclear (McGee, 1992; Kai *et al.* 2001; Canales and Bowers, 2001; Dogra and Pokra, 2005; Centre for Mental Health *et al.*, 2012). One reason has been attributed to the fact that there is very little research that exists regarding how cultural competence could be integrated and addressed within the UK nurse training curriculum (Papadopoulos, 2006; Bhui *et al.*, 2007). However, some nursing scholars are arguing that addressing cultural competence within the nurse curricula remains controversial there is no clear consensus regarding how it should be taught or which theoretical or academic perspectives should underpin this teaching (Gerrish and Papadopoulos, 1999; Papadopoulos, 2006; Allen, 2010).

This lack of progress in educating cultural competent practitioners in nursing education programmes was highlighted further in a reported case in which a young black psychiatric inpatient of Afro-Caribbean origin died while being restrained by nurses following a period during which he was subjected to racial abuse from another patient in a UK psychiatric hospital (The Sainsbury Centre for Mental Health, 2002). The subsequent government inquiry concluded that better training was necessary for the management of imminent violence and for mental health staff to develop cultural competence in care provision (The Sainsbury Centre for Mental Health, 2002; Department of Health, 2003). Even though cultural competence training is recommended as an expected key component of the UK undergraduate nursing curricula (ENB, 1997; Bhui, 2007; QAA, 2009), evidence exist that it does not feature strongly in current nursing education and is indeed absent from many university nursing courses (The Sainsbury Centre for Mental Health, 2002; Pinikahana *et al.*, 2003). These gaps in teaching and learning could be addressed by strengthening cultural competence in undergraduate nursing courses to promote nursing students' learning of the complexities of cultural competence care provision (QAA, 2009; Allen, 2010). Additionally, the lack of progress in developing culturally competent practitioners through nursing education programmes suggests a need for a conceptual framework to underpin development of cultural competence in mental health nursing education. This needs to include the perspectives of key participants involved in the undergraduate nursing education within the UK context, specifically, student nurses and nurse educators. This is to ensure diversity of experience and to make sure it is clinically and educationally relevant.

The literature review indicates that there is a paucity of research studies that have investigated the views of ethnically diverse mental health student nurses and nurse educators regarding their experiences or educational needs with regards to cultural competence training through the curriculum in the UK. There is also a need to explore the teaching methods nurse educators and nursing students perceive to be effective as a vehicle for discussing and developing cultural competence.

In this study, nurse educators and nursing students in direct involvement with nursing training were interviewed to help identify a conceptual framework for developing cultural competence within the UK context.

### **1.3: Aims and purpose of the study**

The aim of the study was to explore and gain an understanding of cultural competence education from the perspectives of the key participants involved in the undergraduate mental health nursing education within the UK context, and to use the findings to develop a conceptual framework for teaching cultural competence.

Specifically, this study set out to seek views from nurse educators and mental health student nurses on the nature and content of a curriculum for educating mental health nurses to enable them to provide care that is efficient and culturally appropriate to the diverse populations. Additionally, their views around what support (if any) in this area they may find helpful to prepare mental health nurses to provide efficient and culturally appropriate care.

### **1.4: The research question**

The research question that guided the study was: *What constitutes a curriculum to prepare mental health nurses to provide efficient and culturally appropriate care for the diverse populations that they will serve?*



## **1.5: Thesis structure**

Chapter 2 reviews the literature to consider how cultural competence has been defined, developed, conceptualised and applied in a range of different health care contexts with particular emphasis on UK mental health nursing practice.

Chapter 3 critically discusses the research methods, design and processes used to collect, analyse and interpret data including justifications and examples of the procedures.

Chapter 4 constitute the main project findings. The chapter sets out the themes that emerged from the analysis of the data. These themes are seen as key to understanding the content in which cultural competence curriculum is implemented.

Chapter 5 discusses the synthesis of the themes to form conceptual framework. It sets out the key messages for mental health nurse educators and curriculum developers on how and what to consider when preparing mental health student nurses for work with a diverse society.

Chapter 6 provides a conclusion of the project and implication of the current research to practice, education and research.

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## **Chapter 2: Literature Review**

### **2:0: Overview of the literature review in this study**

This chapter reviews the literature to consider how cultural competence has been defined, developed, conceptualised and applied in a range of different health care contexts with particular emphasis on UK mental health nursing practice. The chapter starts by providing a brief overview of the literature search process. Following a brief description of the methods used to search the literature, a brief synopsis of how the nursing professionals are trained in UK is given. To provide a framework for discussion, a background on cultural competence is provided to situate its development in the historical, social and political context in which it has emerged with special emphasis to the UK mental health sector. Drawing on the literature, the chapter explores and identifies a range of cultural competence models and frameworks that are used to educate nurses in ways that will enable them to provide care that is both efficient and culturally appropriate (Papadopoulos, 2006). Further, the benefits of implementing cultural competence are explored and discussed in relation to the future nursing graduates, the health care providers and more importantly, the diverse client groups for whom the graduates of these programs will provide services. The literature review concludes by highlighting the main points, identifies the gaps in the evidence based on the topic and provides the justification for this study in this area, as well as the particular approach to research that was taken.

### **2.1: Overview of the literature search process**

The literature reviewed for this study included national and international sources with the purpose of establishing a comprehensive understanding of cultural competence in nursing and other health care professions. A literature search was conducted through the databases which included but not limited to CINAHLPlus, MEDLINE, PubMed, ERIC, ATSIhealth, Cochrane Library, Proquest, RURAL, ScienceDirect, A+Education, IngentaConnect, SAGE, Journals Online, PsycARTICLES, PsycINFO, as well as internet search engines such as Google Scholar for all English language journal articles and books covering the years 1991 to 2013. Documents commonly referred to as 'grey literature', which was available from on-line sources including public and private reports, conference papers, key note speeches, discussion papers and

unpublished dissertation papers were also searched and reviewed. Search strategies covered the following cultural competence associated terms: 'cultural competence', 'transcultural nursing', 'cultural competence models', 'cultural competent care', 'multicultural care', 'cross cultural care', 'cultural competent nursing' and 'models and frameworks of cultural competence'. Searches for reference of references were also conducted and additional material was identified through professional networking and key expertise.

## **2.2: Brief synopsis of how nurses are trained in the United Kingdom**

Undergraduate nurse training is a dynamic way of training the four main branches of nursing across the United Kingdom by the UK higher education establishments (NMC, 2002; QAA, 2009). Undergraduate nurse training education consists of a common foundation programme and four branch programmes to prepare nurses to work in either adult nursing; children's nursing; learning disabilities nursing; or mental health nursing. It is estimated that about one hundred UK universities provide programmes to enable over eleven thousand nurses to enter the professional register of the four branches of nursing every year in the UK (QAA, 2009). This is offered via undergraduate training programmes in universities.

Universities that offer undergraduate nurse training in the UK have great freedom to design their nursing education curriculum (ENB, 1997; QAA, 2001; 2009), and each nursing education provider has its own internal quality assurance procedures. The overall conditions for the nursing education are laid down by the Quality Assurance Agency (QAA) (QAA, 2009). The Quality Assurance Agency safeguards and helps to improve the academic standards and quality of higher education in the UK. The QAA also requires all the nurse education branches to provide the theoretical and clinical knowledge and skills that prepare nursing students for independent and critical judgment, and to enable them to solve problems independently, (QAA, 2001, 2009). Rather than being prescriptive, each university is charged with interpreting and fleshing out its framework to best meet the identified learning needs of their student population, in consultation with their wider professional bodies (ENB, 1997; NMC, 2002; QAA, 2009).

The mental health nursing branch in particular, is an innovative three-year programme that allows mental health nursing to be studied within a multi-professional programme and is also theory and practice based (NMC, 2002; QAA, 2009). Mental health nurses are the largest professional group

delivering mental health care in the UK's National Health Service (NHS) (Jones and Lowe, 2003). Programmes in mental health nursing curricula are designed to prepare nurses to work in a branch of nursing whose precepts acknowledge that nursing is essentially a human activity which has as its core centred on the nurse patient relationships (QAA, 2009).

The knowledge and practical skills required of the mental health nurses are those that facilitate the recognition and achievement of the interpersonal, emotional, behavioural, cognitive, cultural and spiritual needs of clients (QAA, 2009). The programs are meant to prepare mental health nurses who are capable of approaching such needs in a structured way through a systematic process that embraces the concepts of client-centred care (The Sainsbury Centre for Mental Health, 1997; Brown et al., 2006). In developing the mental health nursing curriculum, educators and curriculum developers are encouraged to design the programme that should enable students to develop an awareness of the cultural diversity, values, beliefs and social factors that affect the context of nursing (Papadopoulos, 2006; QAA, 2009). In particular, it has been suggested by some of the UK culturally competent experts that 'nurses must be educated in ways that will enable them to provide care that is both efficient and culturally appropriate', (Papadopoulos, 2006, p.8). Therefore the education and training needs of mental health nurses are of particular significance in terms of equipping nurses who are competent in providing nursing care services to culturally diverse population groups according to individual clients' needs.

### **2.3.0: Background of cultural competence in nursing: An overview**

This section looks at the historical, social and political context in which the need to educate practitioners in ways that will enable them to provide care that is both efficient and culturally appropriate to the populations they will serve emerged. It examines how cultural competence has been conceptualized in a range of health care contexts. The section starts by giving a brief history of transcultural nursing which forms the backbone of cultural competence and cultural competence education. Various definitions of cultural competence found in nursing and health care literature will be provided and synthesised to come up with the working definitions for cultural competence and cultural competence education which are relevant to this study. This section will explore areas most popularly found in transcultural and cultural competence literature.

### **2.3.1: Transcultural nursing**

The field of transcultural nursing started in the United States of America by Madeline Leininger in 1978 (Leininger, 1995) and has been pioneered further in the United Kingdom by Professor Irena Papadopoulos who is one of the leading international experts in the subject (Papadopoulos, 2006). Transcultural nursing was founded and initially developed in the United States of America by Madeline Leininger as the American health care system sought to improve access for the increasing diversity of its population and to address health disparities (Anderson et al., 2003; Leininger, 1995). Madeline Leininger defined transcultural nursing as: ‘a formal area of study and practice focused on holistic culture, care, health and illness patterns of people, with respect to differences and similarities in their cultural values, beliefs, and practices with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse cultures’ (Leininger, 1995, p. 4).

Later, Professor Irena Papadopoulos through working in partnership with her colleagues in UK, expanded the definition and defined transcultural nursing as ‘the study and research of cultural diversities and similarities in health and illness as well as their underpinning societal and organizational structures, in order to understand current practice and to contribute to its future development in a culturally responsive way (Papadopoulos, 2006, p. 8). Professor Irena Papadopoulos and her colleagues expanded further that ‘transcultural nursing requires a commitment to the promotion of anti-oppressive, anti-discriminatory practices’ (Papadopoulos, 2006, p. 8).

Careful consideration of the above definitions suggests that transcultural nursing values and principles place special emphasis on valuing individuals and the commitment to promote equality and diversity respectively.

### 2.3.2: Cultural competence

Cultural competence is a conceptual term that originated from transcultural nursing. This is because the term cultural competence is believed to have first emerged in the health care literature in a 1989 article by Cross and colleagues (Cross et al, 1989; Thomson, 2005). Therefore, it could be argued that the field of cultural competence has emerged over twenty four years globally and more recently in the United Kingdom as part of a strategy to reduce inequalities in health within the increasingly cultural diverse societies (Papadopoulos, 2006). One of the major drivers for it in the United States of America has been to help reduce healthcare disparities (Carter-Pokras and Dogra, 2005, p.1). Similarly, one of the justifications of cultural competence in the United Kingdom was that cultural competence will be used as an instrument to address diversity issues and core knowledge requirement for educating health care practitioners to provide efficient and effective care services utilising anti-oppressive and anti-discriminatory practices (Papadopoulos, 2006; Bhui et al., 2007). Since cultural competence is an emerging field, especially in the UK, efforts to define and implement the principles of cultural competence are still ongoing (Papadopoulos, 2006). For instance, by carefully reviewing the literature from different sources globally, it appears as if there is no clear agreement on a definition for cultural competence (Cross et al., 1989; Leininger, 1991; Campinha-Bacote, 1999; Papadopoulos, 2006; Bhui et al, 2007). If there is no clear consensus to what cultural competence means, it will therefore be difficult to determine how it should be achieved especially when educating health care practitioners to be able to provide care that is both efficient and culturally appropriate.

The literature reviewed yielded several definitions for cultural competence. Among them is Cross et al (2009) (cited in Thompson, 2005) who is believed to have come up with the first definition of cultural competence. Cross et al (2009) defines cultural competence as ‘a set of congruent behaviours, attitudes, and policies that come together in a system or amongst professionals and enable that system, or those professionals to work effectively in cross- cultural situations’ (p.7). On a slightly different note, Tse et al (2005) defined cultural competence as ‘the ability of individuals and systems to respond respectfully and effectively to members of all cultures, races, classes and ethnic backgrounds and religions in a manner that recognises, affirms, and values the cultural similarities and differences and their worth’ (p. 23). On these definitions, there is an

understanding that cultural differences exist among people and that culture profoundly influences individual's beliefs, practices, behaviors and the outcomes of most interventions and services.

One of the most commonly cited definitions of cultural competence in the nursing and healthcare profession was developed by Campinha-Bacote. Campinha-Bacote (1999) defined cultural competence as 'the process in which the healthcare provider consciously strives to achieve the ability to effectively work within the cultural context of a client, be it an individual, family, or community' (p. 203). The aspect of cultural competence in this definition is the service providers' ability to understand the values and beliefs of the client they are providing services to and adjust their therapeutic strategies and or services to meet the client's individual needs. According to this definition, cultural competence is demonstrated when practitioners understand and appreciate differences in health beliefs and behaviours, recognise and respect variations that occur within cultural groups, as well as being able to adjust their practice to provide effective interventions for people from diverse cultures.

Recently, one of the cultural competence experts in the UK, Professor Irena Papadopoulos defined cultural competence as 'a process one goes through in order to continuously develop and refine one's capacity to provide effective health care, taking into consideration people's cultural beliefs, behaviours and needs' (Papadopoulos, 2006, p. 11). More recently, Bhui et al (2007) defined cultural competence as 'a set of skills or processes that enable health care professionals to provide services that are culturally appropriate for the diverse populations that they serve' (p. 4). The main focus of these two definitions appears to be on outcome with the emphasis of increasing performance and the capabilities of future health care professionals when providing services to patients from diverse cultural backgrounds. In addition, Professor Irena Papadopoulos in her definition put much emphasis on the process one goes through, suggesting the learnt element.

On the basis of the review of the cultural competence literature, a synthesized definition of cultural competence that incorporates the most common elements identified in the reviewed literature was proposed. The proposed definition has components that reflect cultural competence as characterized by a learnt or developed process, awareness and respect for differences, refining one's ability to provide effective care, continuing growth of cultural knowledge and skills as well



as adaptations to care services guided by cultural needs of clients and thereby suggesting some needed competencies.

As a result from this synthesis of the above definitions, for the purpose of this study, cultural competence in the context of nursing and health care is defined here as *a learnt or developed skill that enables the healthcare practitioner to serve and interact appropriately, effectively and competently with people from diverse cultural backgrounds.*

Likewise, ‘cultural competence education’ is defined here as *a process of developing the health care practitioner in order for the health care practitioner to have the capacity and enthusiasm to continuously develop self, in order to be able to respond and provide effective health care that is congruent to people’s cultural needs.*

Therefore, the purpose of cultural competence education as viewed in this study is a way of equipping nurses and other health care practitioners with the necessary culturally competent skills, attitude, knowledge and enthusiasm that will enhance the delivery of effective and appropriate health care regardless of cultural and socioeconomic background of patients. This definition is pertinent to mental health nursing professionals and applies well to this study which is aimed at developing a conceptual framework for developing cultural competence that could be used to educate mental health nurses in ways that will enable them to provide care that is both efficient and culturally appropriate.

## **2.4: The benefits of implementing cultural competence in nursing and health care**

The benefits of providing cultural competence nursing care in practice are well documented in nursing and health care literature (Leininger 1995, Papadopoulos, 2006; Campinha-Bacote, 2013) and in policies (Rawls, 1971; United Nations, 2008; Douglas et al, 2009, QAA, 2009). Culturally competent nursing care has been defined by Koskinen, et al (2009) as ‘the sensitivity towards diversity in other people including professional advocacy for human rights and advancement of equal rights for all needing help’ (Koskinen, et al., 2009, p. 503).

Cultural values are reflected in policies regarding human rights, such as the right to protection from oppression (United Nations, 2008), and the principles of Social Justice which demands fairness in the implementation of health care policies (Rawls, 1971; Douglas et al, 2009). Evidence now exists which shows that culture does affect health and illness of clients and the response to treatment and interventions (Wright, 1991; Hughes, 1993; Kirmayer, 2002; Leishman 2004; Betancourt et al., 2005; Jeffreys, 2006). For example studies conducted within the last decade which focused on the genetic differences of diverse ethnic groups with mental health problems have found out that different cultural backgrounds experience the effects of psychotropic drugs differently (Hughes, 1993; Oakley, 1998). Jeffreys (2006) views culture as a vital factor ‘that can make the greatest difference in promoting wellness, preventing illness, restoring health, facilitating coping, and enhancing quality of life for all individuals, families, and communities (p. xiii). About a decade ago, Wright (1991) came up with interesting literature review findings that shows that both culture and social class influenced treatment choices, and that a shared cultural background or social status was more likely to result in the clinician offering psychological treatments. Further, Wright’s literature review showed that clients who did not share the clinician’s cultural background were more likely to receive non-psychological treatments such as medications than those who share clinician’s cultural background (Wright, 1991). Although the reason was not clear in Wright (1991)’s literature review, however, the suggestion was that the clinicians might not be confident about the psychological treatments relevant to the cultural needs of the client.

Furthermore, some scholars have argued that people from different cultures have different beliefs about the causes, diagnosis, and treatment of different health problems and related diseases

(Jackson, 1993; Broome, 2006), and the suggestion was the proper training of health care staff in order for them to be capable of providing a good quality care which is culturally congruent to individual cultural needs of patients (Campinha-Bacote, 2003; Chenoweth et al. 2006, Leininger, and McFarland, 2006; Mahoney, 2006).

In addition, a number of studies have been published on the importance of considering clients' culture as an integral part of assessing their health care needs and planning culturally appropriate nursing care (Andrews and Boyle, 1999; Giger and Davidhizar, 1999; Sealey, et al, 2006). For instance, if nurses are assessing the health and nursing care needs of the clients, they need to be more sensitive to the way the clients communicate to them and also to the communication skills they use to speak to clients. Depending on the individual client's cultural background, some clients may perceive certain non verbal communication skills such as looking directly into the client eyes as aggressive or rude. Similarly, some nursing interventions such as hugging the clients may be perceived provocative, aggressive and rude by some cultures and the clients may react in distressful ways that could be misunderstood by nurses as signs of depression. Because of such possibilities, Kirmayer (2002) challenges practitioners to learn to decode the meaning of somatic and dissociative symptoms that are not simply indices of disorder but part of a language of distress with inter-personal and wider social meanings. This is because people from different cultural backgrounds and in some cases people from the same family or same cultural background may have different beliefs about the cause, diagnosis, and treatment of the illness. Additionally, another challenge could be that an individual client may be acculturated and consciously reject the cultural practices of his cultural group or, that individual client may be immersed in his traditions and accept only the values of his own cultural group. As a result, the same individual client may also be bi-cultural and be quite comfortable in the mainstream culture as well as in his or her own original culture. It is therefore important for nurses and other health care practitioners to gain knowledge about diverse cultures and the degree of acculturation of the individuals if nurses are to provide cultural competent care to their diverse clients.

In recent years, some health care providers worldwide and in the United Kingdom, particularly those in the mental health care service provisions, have embraced cultural competence as a conceptual framework to facilitate more culturally inclusive service provision and as an instrument with which to deal with diversity issues (Papadopoulos, 2006; Bhui, 2007). For the past four decades, the UK health care institutions and practices have come under critical scrutiny

for their racial and cultural bias towards certain members of the society, especially those from Black and ethnic minority backgrounds (Bhui and Bhugra, 1997; Sashidharan, 2001; DOH, 2005). There has also been increasingly national recognition that the UK's mental healthcare provision is inappropriate and poorly addressing the healthcare needs of Black and ethnic minority communities (NIMHE, 2003; DOH, 2005).

Theoretical ideas underpinning cultural competence suggested by Betancourt and colleagues 'is to create a health care system and workforce that is capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency' (Betancourt et al., 2005, p. 499). This idea is supported by Bhui et al (2007) who suggested that cultural competence of the workforce is vital to ensure equity in access to appropriate and high quality care. In addition, cultural competence has been found to be directly related to client empowerment as it leads to negotiation, facilitation of interaction, and adaptation of a regimen that is most likely to result in compliance (Langer, 2002; Caper, 1994). Furthermore, according to some literature (Leininger 1991, Gerrish and Papadopoulos, 1999; Department of Health, 2003; Narayanasamy, 2003), barriers related to the provision of care to some members of ethnic minorities in a society can be eliminated by providing cultural competence education to health care professionals, which in turn increases their cultural sensitivities when working with culturally diverse individuals. A systematic review of literature by Beach et al. (2005) found strong support that cultural competence education enhances the knowledge of health professionals, and that this education assists in changing their attitudes and skills. Others have suggested that 'nursing education is therefore challenged to create culturally competent practitioners who are able to negotiate and adapt their care to diverse people without stereotyping' (Allen, 2010, p. 315).

### **2.5.0: Initiatives, policies, programmes and guidance aimed at developing culturally competent mental health workforce**

The need ‘to develop a mental health workforce capable of delivering effective mental health services to a multicultural population’ and ‘the need to reduce and eliminate ethnic inequalities in mental health service experience and outcome’ in UK mental health services is not a new requirement (NIMHE, 2003, p. 19). Over the past decade, there have been numerous national initiatives, policies, programmes and guidance aimed at developing a mental health work force that is capable of delivering effective mental health services to a multicultural population (NMC, 2002; NIMHE, 2003; DOH, 2005; QAA, 2009). Those national initiatives, policies, programmes and guidance on the provision of mental health services in the UK acknowledged the need for mental health care practitioners such as nurses to be able to deliver health care services in a culturally sensitive way. However, that effort has not resulted in significant change in terms of reducing and eliminating ethnic inequalities in UK mental health service experience and outcome. This section examines at some of the national initiatives, policies, programmes and guidance supporting the need to educate more culturally competent service providers in UK.

#### **2.5.1: The Patient's Charter and You - a Charter for England**

The Patient’s Charter which was first published in October 1991 and subsequently revised and issued in 1995 could be considered as one of the national initiatives aimed at developing culturally competent workforce within the UK National Health Service (NHS). This Charter draws together the rights and standards set out by the UK government to improve the quality of health service delivery to patients (The Patient Charter Unit, 1996). Under “*Personal Consideration and Respect*” heading, the Patient’s Charter standard emphasized ‘respect for privacy, dignity, religious and cultural beliefs’ of patients at all times and in all places’ (The Patient Charter Unit, 1996, p. 2). The Patient Charter standard also required the health professionals to address a wider spectrum of need, and to develop a greater cultural sensitivity to improve the quality of the services provided to all patient groups. In particular, under the same sub-heading, the Patient’s Charter standard specifically emphasised the need for ‘meals served by staff to suit the dietary and religious needs of patients’ (The Patient Charter Unit, 1996, p. 2). By carefully considering such

requirements in the Patient's Charter, it could be inferred that the Patient's Charter demanded some elements of cultural competence from the health care professionals. However, despite this government effort through the Patient's Charter, addressing issues of cultural competence within the health sector remained a big issue as no training was provided to those staff responsible for adhering to the its standards.

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### **2.5.2: The Acheson Report**

One of the guidance towards cultural competence in UK health care could arguably be the Acheson Report (1998), which was an independent inquiry into inequalities in health chaired by Sir Donald Acheson, reporting almost twenty years after the Black Report (1982). In its findings, the Acheson Report concluded that people from low class (in which majority of ethnic minority communities fall into the category) have higher rates of limiting long standing illness than White people. In addition, it was reported that overall people from those poor classes have relatively poor access to primary care, especially in the more deprived areas (Acheson, 1998). One of the solutions recommended by the Acheson inquiry was for different governments departments to take measures to reduce those inequalities. For educational departments such as nursing training institutions, this could mean taking measures to train health workers in cultural sensitivity so that they have the requisite knowledge, skills and attitudes to provide effective healthcare in a multi-cultural society (Acheson, 1998). According to the Acheson report, cultural sensitivity education involves acquiring the skills to understand and be sensitive to cultural differences in the presentation of illness and treatment, and other dimensions of health (Acheson, 1998). However, since the recommendations of the Acheson Report, there still remained evidence that little was done to improve the situation of the poor classes such as ethnic minority communities especially with mental health problems as compared to the White majority of the population (The Sainsbury Centre for Mental Health, 1997; Department of Health, 2003; 2006).

### **2.5.3: The National Service Framework for Mental Health**

When the National Service Framework for Mental Health (NSFMH) was launched in September 1999, it identified the service needs and experiences of people from ethnic minorities as a central theme (DOH, 1999). The NSFMH also recognised that ‘services were not adequately meeting the needs of Black and minority ethnic service users and that community’s lacked confidence in mental health services’ (NIMHE, 2003, p. 3). In particular, the NSFMH cited evidence that ‘people from Black and ethnic minorities were much less likely to be referred for psychological therapies (DOH, 1999, p. 32), that ‘service users from black and ethnic minority communities commonly report that mental health assessments are taken from a perspective which may not always be sympathetic to ethnicity’ (DOH, 1999, p. 44), and it envisioned the possibility of specialist teams for ethnic groups’ (DOH, 1999, p. 47). The NSFMH also signalled the need to ensure consideration of the needs of minority ethnic carers (DOH, 1999, p.73).

As a result, the NSFMH emphasises the need to place people from Black and minority ethnic backgrounds central to the provision of healthcare services, as previous evidence had suggested that their health care needs were inadequately being met (Acheson, 1998; Department of Health, 1999; Gerrish and Papadopoulos, 1999). For example, section one of the NSFMH calls for the active uprooting of all forms of discrimination in the mental health services (Department of Health, 1999b). Such an emphasis by the NSFMH suggests that only culturally competent practitioners such as mental health nurses would be able to effectively contribute to meet such targets and therefore it could be regarded as demanding the need for mental health nurses who are trained in cultural competence. However, there seem to be little evidence that such concerns have led to significant progress in terms of improvement in mental health care given to Black and minority ethnic groups or the training guidance given to practitioners.

#### **2.5.4: The Independent Inquiry into the Death of David Bennett**

The lack of culturally appropriate mental health services as evidenced by ‘differences in the pattern of mental health care received by members of minority ethnic groups in England have been noted since the 1960s, and widely debated since the 1980s’ (Glover and Evison, 2009, p. 12). The evidence became more pronounced by the death, in 1998, of David Bennett, an African Caribbean man who suffered with schizophrenia. David Bennett, a 38-year-old African-Caribbean patient, died on 30 October 1998 in a medium secure psychiatric unit in Norwich after being restrained by NHS staff for around 25 minutes (NSCSHA, 2003). David ‘Rocky’ Bennett was involved in an incident with another patient in the ward. It is believed that each man struck the other and that David Bennett was then subjected to racist abuse. The inquiry believed that this was not the first occasion he had been subjected to racist abuse during his 18 years of treatment (NSCSHA, 2003). It was reported that after the incident, the two patients were separated and David Bennett was moved to another ward. There, it is reported that he hit a nurse (NSCSHA, 2003). He was then restrained by other nurses in a prone position for approximately 25 minutes. During the struggle he collapsed. Nursing staff and paramedics attempted to resuscitate him, but without success. He was taken to the Norfolk and Norwich University Hospital where he was pronounced dead (NSCSHA, 2003). The findings of the independent inquiry into the death of David Bennett revealed that nurses, especially mental health nurses lack the skills and knowledge to deal with clients whose cultural backgrounds are different from them, and advocated cultural awareness training for healthcare professionals as an instrument with which to deal with diversity issues (NSCSHA, 2003).

The report of the independent inquiry into the death of David Bennett made important recommendations about the way that mental health care is delivered to service users, especially those from BME communities (NSCSHA, 2003; DOH, 2005). Following the publication of the report, for the first time, the UK government through the Health Minister Rossie Winterton, effectively admitted that the National Health Service (NHS) systematically discriminates against and fails the clients from minority ethnic backgrounds and describes this as ‘arguably both unethical and unlawful’, (Downey, 2006, p. 13). The Health Minister further revealed the governmental concern that there has been little progress in the past years since the death of a black psychiatric patient David Rocky Bennett in a secure mental health unit. One of the first key



recommendations in the report was that ‘all who work in mental health services should receive training in cultural awareness and sensitivity’ (DOH, 2005, p. 21). Such recommendation is one of the drivers for this study to develop an educational framework that will enable mental health nurses to provide care that is both efficient and culturally appropriate to diverse populations.

#### **2.5.5: National Institute for Mental Health (NIMH) in England**

In 2003, the National Institute for Mental Health (NIMH) in England published the first national approach aimed at reducing and eliminating ethnic inequalities in service experience and outcome to people with mental health problems from diverse cultural backgrounds. This document represented a landmark in UK health care in terms of providing a cultural capability framework aimed at tackling institutional discrimination while educating the workforce to improve clinical practice with diverse cultural groups (NIMH, 2003). One of the objectives in the NIMH publication was the need for mandatory training in cultural awareness and recruitment of multicultural workforce so that the workforce in mental health reflects the people it serves (NIMH, 2003). A year later, as a follow up to the document, the government published an ‘Action Plan Report’ which was aimed at building a fair and more inclusive society for all people with mental health problems irrespective of cultural background (NIMH, 2003). Despite such approaches and actions by the UK government, evidence exist to suggest that more needs to be done to tackle the problems experienced by ethnic minority cultures with mental health problems (Leishman, 2004; Bhui et al, 2007).

### **2.5.6: Delivering Race Equality in Mental Health Care: An Action Plan**

Launched in 2005, the *Delivering Race Equality in Mental Health Care (DRE)* was a five year national programme which ended in 2010. DRE was a five year programme that aimed to support the development of better mental health services which met the needs of England's increasingly diverse population (DOH and NMH DU, 2009). In particular, the *DRE* was an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status, including those of Irish or Mediterranean origin and east European migrants (DOH, 2005). It was also an action plan to develop a workforce that can deliver equitable care to BME populations in order to improve clinical services for BME populations thereby, improving those services for specific populations (DOH, 2005). For instance, in its conclusion remarks, the DRE Action Plan recommends the need for a performance framework that can deliver better and more culturally appropriate, clinically effective and recovery-oriented care for BME communities (DOH, 2005, 39). Therefore, the The DRE action plan aimed to improve mental health services for all people of minority ethnic status in England irrespective of their cultural backgrounds.

According to the review by the Department of Health Mental Health Division and National Mental Health Development Unit (2009), DRE was needed because it was felt that patients from BME backgrounds were not getting the mental health services to which they were entitled (p. 4.). Further, The DRE document combined a five-year action plan for reducing inequalities in Black and minority ethnic patient's access to, experience of, and outcomes from mental health services; and the Government response to the recommendations made by the enquiry into the death of David Bennett (DOH, 2005). For example, the DRE accepted the recommendations from the David Bennett inquiry and 'recommended staff providing mental health services to have the right training, supervision and leadership if they are to give all their patients culturally sensitive and safe care' (DOH, 2005, p. 8). In other words, the DRE is recommending staff to be educated in ways that will enable them to provide services that are culturally appropriate to diverse patients. Therefore, the DRE programme aimed to change attitudes and behaviours as well as how mental health services were organized and provided in the United Kingdom (DOH, 2005; DOH and NMH DU, 2009).

However, following a period of significant investment, particularly through the *Delivering Race Equality in Mental Healthcare* initiative, the *Count Me In* 2010 census of inpatients (Care Quality Commission, 2010), found that there was little improvement in key measures of race equality, and that in some cases there was a widening of the variations by ethnicity. The *Delivering Race Equality in mental health care five year review* (DOH, 2010) does however demonstrate that there has been significant effort exerted by national teams, local services, together with service users and carers, in attempting to make improvements' (Cotton, 2012, p.9). However, there was no indication in the document as to why efforts were unsuccessful. Further, the review of the programme suggested that there are four key areas that any future programme of work should focus on for improving services. One of those four areas included: the re-thinking workforce development to improve skills and capabilities (DOH, 2010). Therefore focusing this study on developing a conceptual framework of teaching cultural competence within the undergraduate mental health nurse training may contribute to meeting the requirements of the DRE action and review plan.

#### **2.5.7: Inside Outside – public Consultation Document**

Another initiative towards cultural competence in UK could be considered as the *Inside Outside – Public Consultation Document*. For the first time, the group responsible for much of the detailed policy in the National Health Service -the National Institute for Mental Health commissioned an outside expert, Professor Sashidharan, 'to produce a critique of the issues needing to be addressed' (Glover and Evison, 2009, p. 12). Professor Sashidharan prepared a report namely the *Inside Outside – Public Consultation Document*. His report, *Inside Outside: Improving Mental Health Services for Ethnic Minority Communities in England* discussed organizational and professional issues in depth from the context of Black and ethnic minority patients' experiences of care (Sashidharan, 2003). The report signaled reform of mental health care for BME communities. For example, the document identified three key objectives:

- To reduce and eliminate ethnic inequalities in mental health service experience and outcome;

- To develop a mental health work force that is capable of delivering effective mental health services to a multicultural population;
- To enhance or build capacity within black and minority communities and the voluntary sector for dealing with mental health and mental ill health (NIMHE, 2003, p. 19).

Therefore, one of the responses of the *Inside Outside* document was a clear message that ‘BME communities were dissatisfied with the quality of mental health care they receive as well as that the mental health professionals needed training to deliver care in a culturally competent way’ (DOH, 2005, p. 13). It is therefore clear that one of the main objectives of the *Inside Outside* document was to enhance ‘cultural capability of mental health services through training in cultural competencies’ (NIMHE, 2003, p. 30), and that ‘undergraduate training leading to professional qualifications must include cultural competency components’ (NIMHE, 2003, p. 31). As described by Glover and Evison (2009), the type of new mental health care considered in the *Inside Outside* report by Professor Sashidharan is ‘central to the vision of reformed, person-centred and community located service (p. 13). While there has been a general acknowledgement that training staff to acquire the competencies to work within a multicultural community is a good idea and that staff working with culturally diverse population should have training in this area, there is no consensus on the content, style or delivery of such training. Recent work in this area (Papadopoulos, 2006) has begun to specify the core competencies, skills, values and knowledge base which are to be included in undergraduate mental health nurse training as evidenced in later sections of this study.

### **2.5.8: No Health without Mental Health: Implementation Framework**

Recently, the Centre for Mental Health, the Department of Health, the Mind, the NHS Confederation Mental Health Network, the Rethink Mental Illness and the Turning Point jointly published *No Health Without Mental Health* (Centre for Mental Health et al, 2012), which is the cross-government, all-age framework for mental health in England. The framework addresses issues around the inequalities that lead to poor mental health, inequalities that result from poor mental health and inequalities in service provision. The framework is committed to improving the mental health and wellbeing of the whole population, including the life chances of people with

mental health conditions irrespective of their social, racial and cultural backgrounds (Centre for Mental Health et al, 2012). Given the evidence that cultural and social disadvantage is a key driver of ethnic inequalities in mental health (Cooper et al., 2008), this provides a strong evidence for the need for nurses who are educated in ways that will enable them to provide efficient and culturally appropriate care for socially and culturally disadvantaged people with mental health problems. This document arguably puts more demands on nursing faculty to incorporate content related to cultural competence in especially in the undergraduate mental health nursing curriculum (QAA, 2009), if life chances for diverse people with mental health problems are to be achieved.

### **2.5.9: Nursing Professional and Accreditation Bodies**

Several nursing accreditation bodies have instituted guidelines or standards in cultural competence for their memberships which have now been made an explicit requirement for nursing education in the United Kingdom (NMC, 2002; QAA, 2001; 2009). For example, the Nursing and Midwifery Council (NMC) issued cultural proficiency guidelines for preparing nurses in culturally competence as an integral part of pre-registration nurse training (NMC, 2002). This NMC accreditation body sets up the code of professional conduct with the aim of protecting all patients from nurses' actions or inactions. For instance, Section 2 of the Professional Conduct for Nurses, Midwives and Health Visitor requires 'nurses to recognise and respect the role of all patients and clients as partners in their care and the contribution they can make to it' without any form of discrimination (NMC, 2002, s2.1). The second subsection of the same code further went on to say that nurses are 'personally accountable for ensuring that they promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs (NMC 2002, s.2.2). The NMC clearly expects nurses to respect diversity and culturally competence learning is seen as a lifelong objective, (NMC, 2002). The NMC standards are in line with the earlier objectives of the English Nursing Board (ENB) which endorsed educational standards that made explicit requirement the need for the UK nursing curriculum to prepare practitioners to deliver care in a multicultural context in order to enable them to challenge discriminatory practices (ENB, 1997).

New standards have also been implemented by the Quality Assurance Agency (QAA), the accreditation body responsible for the benchmarking of the various higher education disciplines including the nurse training. In particular, the QAA has made it clear that the cultural care needs, values and principles are to be an explicit requirement of nursing education in Britain, (QAA 2001, p. 2). Their statement for the health related curriculum including the nursing curriculum is to include ‘cultural competence focused education that prepares future mental health nurses to practice in an anti-discriminatory, anti-oppressive manner and to contribute to the promotion of social inclusion’ (QAA 2001, p. 3). Further, in developing the curriculum, the QAA encouraged educators and curriculum developers to design nursing programmes that should enable students to develop an awareness of the cultural diversity, values, beliefs and social factors that affect the context of nursing (QAA, 2009).

Cultural competence is recognised as an essential element or an explicit requirement by professional bodies for nursing education in the United Kingdom (NMC, 2002; QAA, 2001; 2009), although such bodies do not necessarily give explicit references to cultural competence. Universities that offer undergraduate nurse training in the UK are therefore directed to develop cultural competence for their learners, but can exercise discretion in relation to how this is achieved, as they have great freedom to design their nursing education curriculum (ENB, 1997; QAA, 2001; 2009).

#### **2.5.10: The Race Relations (Amendment) Act 2000**

The policies towards culturally competence in UK are further supported by the Race Relations (Amendment) Act 2000 legislation. The Race Relations (Amendment) Act 2000 places a duty on all public authorities to tackle racism in service delivery. Therefore, the obligation is on authorities to bridge their knowledge gap, challenge prejudices and stereotypes and respect the needs of citizens from all cultures (Papadopoulos, et al, 2004). Further, the Race Relations (Amendment) Act 2000 requires public organisations to set arrangements for training staff in the necessary knowledge and skills they will need ‘to work respectfully and effectively with people from minority ethnic communities’ (NIMHE, 2003, p. 22).

### **2.5.11: The Principles of Social Justice and Human Rights**

In recent years, a set of universally applicable standards of practice for culturally competent care were developed by the participating members of the American Academy of Nursing Expert Panel on Cultural Competence as a way of reducing the inequalities in health globally, and to assist nurses to place cultural competence as a priority of care (Douglas et al, 2009). These standards are based on a framework of Social Justice (Rawls, 1971), that is, ‘the belief that every individual and group is entitled to fair and equal rights and participation in social, educational, economic, and, specifically in this context, health care opportunities’ (Douglas et al, 2011, p. 317). Through the application of the principles of Social Justice and the provision of culturally competent care standards, it is hoped that nurses around the globe may use the standards as ‘a guide and resource for nurses in clinical practice, research, education, and administration by emphasizing cultural competence as a priority of care for the populations they serve’ (Douglas et al, 2011, p. 318).

### **2.5.12: Conclusions: Initiatives, policies, programmes and guidance aimed at developing culturally competent mental health workforce**

Over the years, there have been significant policy and service development within mainstream mental health services as depicted above by the initiatives, policies and programmes aimed at developing culturally competent mental health workforce. Reviewed evidence from these drivers towards cultural competence in UK have shown that over the years, the need for cultural competence within the UK mental health systems has been focus of much concern, debate and research. However, there seem to be little evidence that such concerns have led to significant progress in terms of improvement in mental health care given to Black and minority ethnic groups. This may suggest that challenges experienced by mental health nurses in terms of trying to deliver quality congruent care to Black and minority groups within the UK mental health services need a different approach.

The initiatives, policies and programmes aimed at improving access, experience and outcomes for BME service users indicate many campaigns have been initiated for health care educational programs to be aware of the need to increase the cultural competence of the nursing workforce, especially in mental health nursing (Department of Health, 1992; 2006; ENB, 1997; NMC, 2002; QAA, 2009; Douglas et al, 2011). However, despite efforts to prepare a more culturally competent mental health care workforce in the formal educational setting, studies indicate that nurses, especially mental health nurses (The Sainsbury Centre for Mental Health, 2002; Department of Health, 2003) are not ready to meet the challenges posed by an increasingly culturally diverse society (Narayanasamy, 2003; Leishman, 2004; Bhui et al., 2007, Allen, 2010). Therefore, the critical issue remains how can we best educate mental health nurses ‘to provide care that is both efficient and culturally appropriate’ to the diverse populations they will serve (Papadopoulos, 2006, p. 8). This is a key focus to this study.



## **2.6.0: Overview of the selected frameworks for developing cultural competence**

The nursing profession has a long history for using nursing theories and models to provide a framework for thought in which to examine. In addition, a sound theoretical framework is needed to guide all phases of the nursing process, including planning, implementing, and evaluating nursing care, as well as guiding the learning and teaching. The literature is saturated with cultural competence models and frameworks that have been developed with the aim of assisting health care practitioners to provide effective health care that is relevant to people's cultural needs. Some of those models and frameworks focus on the levels of development whilst others are keen to explore the components. Whilst there are many models and frameworks for developing cultural competence in different fields, this section provides a brief review of some of them and is not exhaustive. Included here are those relevant to the nursing sector. The section is not intended to be a complete, comprehensive critique of each one but, it introduces the key elements of each of each of the selected model or framework including an outline of their development, the applications and the possible limitations relating to nursing practice. In the reviewed literature, many nursing scholars, theorists and researchers generally make no distinction between models and frameworks and they frequently use them interchangeably, for instance, a cultural competence framework can be seen as a cultural competence model. Accordingly, in this section, cultural competence models can be referred to as cultural competence frameworks.

### **2.6.1: Cultural Care Diversity and Universality Theory/Model and Sunrise Model**

Madeleine Leininger's 'Cultural Care Diversity and Universality Theory and the Sunrise Model' (Leininger, 1993) for developing cultural competence were developed in the United States of America and are perhaps the most well known methodological models in nursing literature on culture and health (Reynolds and Leininger, 1993; Leininger and McFarland, 2006). The model includes cognitive and behavioural components, as well as attending to contextual elements of cultural competence. The model aims to assist nurses in the identification of patterns of human behaviour in relationship to care and caring by guiding nurses in the assessment, planning, implementation, and evaluation of their care (Leininger 1993; Leininger and McFarland, 2006).

The central purpose of the theory is to discover and explain diverse and universal culturally based care factors influencing the health, well-being, illness, or death of individuals or groups (Leininger, 1995). In their research study findings, Foley and Wurmser (2004) suggested that the use of Madeline Leininger's transcultural model might assist nurses in making culturally competent decisions and in implementing actions in practice so that they can develop cultural competence, cultural awareness, cultural knowledge and cultural sensitive care. This was because, in developing the model, Leininger considered cultural blindness, culture shock, culture imposition, ethnocentrism and cultural relativism as barriers to developing knowledge about other's culture (Leininger, 1995).

In developing the model, Leininger claims that the theory of cultural care diversity and universality is holistic (Leininger, 1995). The theory is claimed by Leininger to be holistic and encompassing both the diversity and universality of concepts in nursing care, however, application of the theory appears to be complex. Many of the concepts are abstract in nature and together with the layered way in which it is constructed; the theory requires a deeper understanding of how these interrelate. In addition, Leininger's model with its emphasis on cultural sensitivity and cultural congruence has been criticised on the grounds that it assumes that knowledge of different cultures will improve care and services (Culley, 1996). Culley (2001) further argues that transcultural nursing's focus on the essence of particular cultures limits culture to a static entity and reduces understanding of peoples' behaviour to prescribed cultural norms. In addition, Culley (2001) further states that such an approach promotes cultural stereotyping with the risk of discrimination as it fails to account for individual and family differences within cultural groups.

As a result, by focusing on cultural differences and deficits, the approach has a potential to make the culture the problem, and may give rise to a victim blaming stance. This is because the cultural analysis that is based on the notion of cultural differences as cultural deficits are more likely to reinforce stereotypes and perpetuate the power distance between the health care practitioners and the clients (Culley, 1996, 2001; Mahoney, 2006). For example, Mahoney (2006) has warned against relying on models that promote culture-specific care rather than on providing individualized patient care basing on the fact that nurses encounter many different cultures on a daily basis in their practice. Furthermore, of particular interest to this study, with such a model, the major barrier according to Jeffreys (2006) is the limited research of evaluating the effectiveness of teaching interventions on the development of cultural competence.

### **2.6.2: Culturally Competent Community Care (CCCC) Model**

Based on literature review and concept analysis, Kim-Godwin and colleagues (2001) developed their Culturally Competent Community Care Model (CCCC) model (Kim-Godwin et al., 2001). In developing the model, Kim-Godwin et al. (2001) conducted interviews with community health nurses and community experts. The model is aimed at providing specific guidelines for community nurses in developing and assessing cultural competence and meeting the health needs of diverse communities and with particular focus on ethnic populations in the State of North Carolina in the United States of America (Kim-Godwin et al., 2001). The model ‘focuses on the relationship between cultural competence and health outcomes for culturally diverse populations’ and the model proposed four dimensions of culturally competent care which are; ‘caring, cultural sensitivity, cultural knowledge, and cultural skills’ (Kim-Godwin et al., 2001, p. 918). Finally, Kim-Godwin et al. (2001) tested their model with a convenience sample of 192 nursing students and yielded consistent and positive results.

However, the main shortfall of the model may be in relation to its applicability to other countries such as the United Kingdom. This is because the model was developed specifically to meet the challenges faced by community nurses of the North Carolina (USA) in serving their immigrant population. Therefore, the variation of standards among political, economic and social systems of North Carolina in USA and the context within which those standards are practiced may rule out a single set of cultural competence frameworks that fits all cultures and other countries. Furthermore, the nursing students were never involved in the development of the model, but they were only involved in testing the model.

### **2.6.3: The Process of Cultural Competence in the Delivery of Healthcare Services**

The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2007) is one of the developmental models that health care practitioners can use as a framework for developing and implementing cultural competent care services (Campinha-Bacote, 2002; 2007). The model was first developed in 1991 by Campinha-Bacote in the United States of America

during the time of ‘unrest and conflict in the area of race relations’ (Campinha-Bacote, 2002, p.181). The model was subsequently revised a number of times by her. This model includes both cognitive and behavioural components and describes cultural competence as ‘the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client’ (Campinha-Bacote, 2002, p. 181). This model views cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire as the five constructs of cultural competence (Campinha-Bacote, 2007). According to Campinha-Bacote (2002), this ongoing process involves the integration of these constructs which, she previously summarised as ‘the essential elements of cultural competence constructs in literature’ (Campinha-Bacote 1999, p. 203). The model was recently revised in 2010 to reflect the construct of ‘many cultural encounters through continuous cultural encounters’ which the model proclaims that one has to through cultural awareness, cultural knowledge, cultural skill and cultural desire (Campinha-Bacote, 2013). From this perspective, the model put more emphasis on the fact that that cultural competence can be viewed as an ongoing journey of unremitting cultural encounters (Campinha-Bacote, 2007).

The model views cultural competence as the process or journey of becoming cultural competent rather than an ultimate goal that can be attained by attending any course or training (Campinha-Bacote, 2007). Based on the model and to be used as part of the model, Campinha- Bacote developed a 20-item instrument that measures the model’s constructs (Campinha-Bacote, 1999; 2002). In 2001, Camphina-Bacote successfully used and tested her model with a sample of rehabilitation practitioners serving people with disabilities (Camphina- Bacote (2001). The evaluation of their model is in line with evidence that exist to indicate that the studies that evaluated interventions designed to improve the cultural competence training of health professionals improves the attitudes, knowledge and skills of trainees, and that the training can impact patient satisfaction (Beach et al., 2005).

Although this model is claimed to have been evaluated in practice Camphina- Bacote (2001), however, the inverted ‘20-item instrument that measures the model’s constructs does not measure the construct of cultural desire’ which leaves it as an area for further development of the model (Campinha-Bacote, 2002, p.184). This therefore raises questions on the effectiveness of the model as a whole and or the trustworthiness of the measuring instrument because leaving one area may suggest lack of proper evaluation.

#### **2.6.4: The Giger and Davidhizar Transcultural Assessment Model**

The Giger and Davidhizar Transcultural Assessment Model (Giger and Davidhizar, 2002) is another developmental model of cultural competence that was developed in 1988, in response to the need for Canadian ‘nursing students in an undergraduate program to assess and provide care for patients that were culturally diverse’ (Giger and Davidhizar, 2002. p. 185). In developing the model, Giger and Davidhizar view cultural competence as ‘a dynamic, fluid, continuous process whereby an individual, system, or health care agency finds meaningful and useful care-delivery strategies based on the knowledge of the cultural heritage, beliefs, attitudes, and behaviours of those to whom they render care’ (Giger and Davidhizar, 1999, p. 8).

The model postulates that each individual is culturally unique and should be assessed according to six cultural phenomena which are: ‘communication, space, social organization, time, environmental control, and biological variations’ (Giger and Davidhizar, 2002, p. 185). In addition, The Giger and Davidhizar Transcultural Model focuses more on the behavioural components and proposes a framework that facilitates assessment of the individual using a set of questions constructed under each of the six areas to generate information useful in planning care congruent with the individual's cultural orientation and individual needs (Giger and Davidhizar, 2008). This is because the model views the person as a unique cultural being influenced by culture, ethnicity, and religion (Giger and Davidhizar, 2008).

Although the model can be used as a tool that explores issues about the six named areas of assessment, the main weakness of this model is that there seem to be no further information of how it should be evaluated in nurse education practice. In addition, the six areas borrow from a wide range of biomedical and social science disciplines and therefore the breadth and depth of understanding of the concepts may not lend themselves to application, unless one is fully conversant with the area of cultural knowledge. For instance, the idea of time and its meanings in different cultural contexts may not be fully appreciated. For example, some Westerners may associate time with money while some African cultures may think that there is no hurry in Africa.

### **2.6.5: The Purnell Model for Cultural Competence**

Another cited example of developmental models of cultural competence includes Purnell Model for Cultural Competence (Purnell and Paulanka, 1998; Purnell, 2000). The Purnell Model for Cultural Competence was originally developed in 1995 to provide an organizing framework for nurses to use as a cultural assessment tool (Purnell, 2000). In particular, the model was ‘started as an organizing framework for student nurses to use as a clinical assessment tool’ (Purnell, 2002, p. 193).

The model contains a diagram, metaparadigm concepts, and the nonlinear cultural competence concepts. The model was developed as a product of the author’s lived experiences, clinical practice, observations, personal readings, research and from working with staff and students in culturally diverse clinical settings (Purnell, 2000). The model is said to be ‘a conceptualization from multiple theories and a research base gained from organizational/administrative theories, anthropology, sociology, anatomy and physiology, biology, psychology, religion, history, linguistics, nutrition, and the clinical practice settings in nursing and medicine’ (Purnell, 2000, p. 40). The model contains twelve domains and their major concepts with terms borrowed from different disciplines. The model was further redeveloped adding a schematic, the meta paradigm concepts, and the cultural competence scale. In the diagrammatic representation of the model, Purnell and Paulanka use concentric circles to locate the macro aspects and micro aspects. Purnell and Paulanka (1998) suggest that the model is informed by a range of fields of inquiry that include ‘biology, anthropology, sociology, economics, geography, history, ecology, physiology, psychology, political science, pharmacology, and nutrition as well as communication, family development, and social support’ (p. 8-9) and that the model can be used by many different professionals. The model conceptualises the development of cultural competence along an upward curve of learning and practice, viewing the practitioner achieving cultural competence by moving through the four main levels namely; ‘unconscious incompetence, conscious incompetence, conscious competence and finally unconscious competence’ (Purnell, 2000, p. 42).

The author of the model claims that the model is showing some promise for future testing through critical reasoning, descriptions of personal experiences, and application to practice and administration (Purnell, 2002). In addition, one university in USA is claimed to have used the

model to teach population-based care in which students apply the information in community health settings (Purnell, 2002, p. 196). However, although the model tries to be all-inclusive in its application, the risk may be that it may not be appropriate to nurse practitioners and in nurse training unless the breadth and depth of their knowledge and skills is matched with the requirements of health care users. Furthermore, because Purnell's model is directed towards helping health professionals from many disciplines to increase cultural competence in all practice settings, hence, it has been classified as a 'complexity and holographic theory' (Purnell, 2002, p. 193). Additionally, besides the claims that different professionals across the globe have successfully used the model, there is also a need to clearly expound how each health profession can use the model and apply the concepts in practice as this was left by the authors as 'an area for further development' (Purnell, 2002, p. 196).

## **2.6.6: The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence**

The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence is another developmental model of cultural competence (Papadopoulos, 2006). The model was developed in UK and 'has proved its usefulness in education, in ethical decision making and in research' (Papadopoulos, 2006, p. xii). In order to promote the inclusion of culture into the nursing curricula and help their students develop cultural competence, Papadopoulos and colleagues published their model of cultural competence which they had developed in 1994 (Papadopoulos, 2006) following a research study into transcultural nursing education (Papadopoulos et al, 1995).

In this model, cultural competence is defined as 'a process one goes through in order to continuously develop and refine one's capacity to provide effective health care, taking into consideration people's cultural beliefs, behaviours and needs' (Papadopoulos, 2006, p. 11). The authors further argued that cultural competence is both a process and an output that results from the synthesis of knowledge and skills that are continuously acquired by practitioners during their personal and professional lives (Papadopoulos, 2006). Papadopoulos (2006) considers that promotion of cultural competence, the ability to undertake effective health care given to peoples'

cultural beliefs and values, is the aim of including culture in nursing curricula. Accordingly, cultural competence is considered by the authors of the model as both a process inherent to effective nursing care provision and an outcome (Papadopoulos, 2006). Further, in the Papadopoulos, Tilki and Taylor model, cultural competence results from development of four intersecting constructs and stages (Papadopoulos, 2006). Professor Irena Papadopoulos who is one of the key experts of the model claimed that ‘the underpinning values of the model are based on human rights, socio-political systems, intercultural relations, human ethics and human caring’ (Papadopoulos, 2006, p. 10). The model consist of four stages of development namely; cultural awareness, knowledge, sensitivity and competence (Papadopoulos et al., 1998).

The first stage in their model is cultural awareness which the authors claim that it begins with an examination of one personal value base and beliefs (Papadopoulos et al., 1998; Papadopoulos, 2006). This also includes an examination of the practitioner’s own personal beliefs, values, identity and cultural history, and how these influence practitioners’ lives and the lives of patients/clients for whom practitioners provide care (Papadopoulos, 2006).

This includes domains of self-awareness, cultural identity, awareness of ethnocentrism and stereotyping. The authors claim that individual values and beliefs are the principles that individuals use to guide their lives and to make decisions or judgements (Papadopoulos, 2006). The author of the model further went to say that those values and beliefs are acquired from an early age and are therefore influenced by the family and close social environment (Papadopoulos, 2006). The lead author of the model recommended that in self awareness stage, before one attempts to understand the importance of the ethnic origins of other people, they must try and understand their own (Papadopoulos, 2006). In addition, Papadopoulos (2006) brought in some sub construct related to both cultural awareness and cultural knowledge of ethno history as defined by Lininger (1995). Papadopoulos (2006) claimed that individual must ‘try to gain some understanding of the historical, geographical and sociocultural background of people they care for’ in order to understand the health issues of those people (p. 13). The author of this current study strongly agrees with Papadopoulos (2006)’s claims especially from the overlapping sub construct of ethno-history.

The second stage in the model is cultural knowledge which involves a commitment to learning about different cultures and their beliefs, values and practices (Papadopoulos, 2006). Cultural knowledge can be gained in a number of ways according to the authors of the model



Papadopoulos et al., 1998). For example, meaningful contact with people from different ethnic groups can enhance knowledge around their health beliefs and behaviours as well as raise understanding around the problems they face. In addition, through sociological study, the students can be encouraged to learn about power, such as professional power and control, or make links between personal position and structural inequalities (Papadopoulos et al., 1998). Further, Papadopoulos (2006) pointed out as an example that the study of health inequalities can form an essential part of knowledge as individuals may see the connection between the prevalence of health in minority ethnic groups and structural inequalities.

The third stage is cultural sensitivity (Papadopoulos et al., 1998; Papadopoulos, 2006). An important element in achieving cultural sensitivity according to the model is how professionals view people in their care (Papadopoulos, 2006). For instance, a given example was that ‘unless clients are considered as true partners, culturally sensitive care is not being achieved’ and to do otherwise only means that ‘nurses and other professionals risk using power in an oppressive way (Papadopoulos, 2006, p. 16). The authors further said that equal partnerships involve trust, acceptance and respect as well as facilitation and negotiation (Papadopoulos, 2006). The model further claims that effective interpersonal communication and trust are essential to the development of such relationships (Papadopoulos, 2006).

The fourth and final stage of the model is ‘cultural competence’ (Papadopoulos et al., 1998). The achievement of the fourth stage (cultural competence) according to the model requires the synthesis and application of previously gained awareness, knowledge and sensitivity (Papadopoulos, 2006). The lead author of the model stresses that cultural competence stage can only be reached by achieving a true understanding of the first three stages, and it involves the assimilation of this understanding in the skills necessary to practise cultural competence in the workplace (Papadopoulos, 2006). In addition, the lead author claims that an important part of this stage is to both recognise and challenge any form of discrimination, including racism, in the healthcare setting (Papadopoulos, 2006). Further focus is given to practical skills such as assessment of needs, clinical diagnosis and other caring skills (Papadopoulos, 2006, p. 18). According to the authors of the model, the most important component of this stage of development is the ability to recognise and challenge racism and other forms of discrimination and oppressive practice (Papadopoulos et al., 1998; 2004). This model combines both the multi-

culturalist and the anti- racist perspectives and facilitates the development of a broader understanding around inequalities, human and citizenship rights, whilst promoting the development of skills needed to bring about change at the patient/client level (Papadopoulos et al., 1998; 2004).

Unlike other available models reviewed in this study, this model was developed with the UK context and has been reported to be useful in education because of its ability to promote the inclusion of culture into the nursing education curricula and has the potential of helping students to develop competence (Papadopoulos, 2006). Therefore, model could be regarded as the landmark for providing structure which could improve cultural competence education in nursing especially within the UK context.

### 2.6.7: Conclusions: Frameworks for developing cultural competence

The need for cultural competence in nursing especially in the mental health sector and the demand for nurses who have the ability to work with diverse client groups in contemporary diverse societies are nowadays are well known and widely documented. Cultural competence frameworks such as Leininger's *Sunrise Model* (Leininger, 1995), Purnell's *Cultural Competency Model* (Purnell and Paulanska, 2003), Campinha-Bacote's model of *Cultural Competence in the Delivery of Healthcare Services* (Campinha-Bacote, 2007), The Giger and Davidhizar's *Transcultural Assessment Model* (Giger and Davidhizar, 1999), The Papadopoulos, Tilki and Taylor's *Model for Developing Cultural Competence* (Papadopoulos, 2006) and others provide detailed frameworks for the development of culturally competent nursing. However, reviewing available literature on the available models and frameworks for developing cultural competence, there is generally very little description or analysis of the composition of cultural competence training programs, other than noting the prescription of what should be included in the training programs. For example, the reviewed available models typically document that the key elements that makes staff to be cultural competent are knowledge, awareness, desire (Leininger, 1995; Giger and Davidhizar, 1999; Campinha-Bacote, 2007), or that the aim was to increase knowledge of practitioners and to reduce prejudice towards certain cultural groups (Papadopoulos, 2006).

Further, existing frameworks and models of cultural competence have much in common but there are some differences. In a detailed analysis of the reviewed cultural competence frameworks in this current study, the researcher identifies some themes common to all frameworks. These themes are namely an awareness of cultural differences among people, an ability to provide individualized care based on individual cultural, ethnic and or racial differences, knowledge of cultural uniqueness of individuals and promoting or enhancing cultural competence through continuous process. Additionally, some of the reviewed models explicitly address learning about the context of the people they are trying to serve (Leininger, 1993; Kim-Godwin et al., 2001), and the main focus of all of the reviewed models is changing the behaviours of the professional practitioners and/or changing their interactions with people who are culturally different from them. However, the precise content or the depth to which these issues are discussed and addressed in education setting is rarely addressed in this literature on the selected available models and frameworks of cultural competence.

While there are some available cultural competence models and approaches that were developed from the perspective of qualified health care practitioners (Leininger, 1993; Campinha- Bacote, 1999), and community qualified nurses in general (Kim-Godwin et al., 2001), there is an absence of research that exclusively addresses nursing students and nursing educators' perspectives within the UK context. This literature review revealed that the available models and measures for developing cultural competence exist within political, economic and social systems, and that many health care organisations especially in the developed countries such as Canada, United State of America have defined and developed cultural competence care models and measures for their specific populations and from the perspective of their systems. For instance, the cultural competence frameworks developed in the United States of America (Leininger, 1995; Kim-Godwin et al., 2001; Purnell, 2002; Campinha-Bacote, 2007) and in Canada (Giger and Davidhizar, 1999) place less emphasis on racism and other forms of discrimination. However, by contrast, Papadopoulos et al. (2006) framework which was developed from the UK context emphasises not only cultural dimensions but also addresses discrimination and disadvantage experienced by people from migrant backgrounds. Therefore, arguably, the variation of standards among political, economic and social systems of countries and the context within which those standards are practiced may rule out a single set of cultural competence frameworks, measures or best practice that fits all cultures and all countries. In addition, all the reviewed models and frameworks of cultural competence seem to be based on the premise that a person's cultural background affects several aspects of their lives. This therefore suggest that nurses and other health care practitioners need to develop an understanding of cultural competence using conceptual frameworks that are relevant to their own context in order to provide effective and appropriate care to patients from different cultural backgrounds.

## **2.7: Summary of the literature review and gaps in the evidence base**

The review of literature was conducted with the purpose of establishing a comprehensive understanding of cultural competence and cultural competent care and to identify the most prevalent models, measures and best practice utilised to train cultural competence in nursing and health care professions. The review of the literature revealed that the theoretical ideas of cultural competence, questions relating to the teaching of cultural competence and the provision of cultural competent care within the nursing care have been placed firmly on the research agenda worldwide and in UK (Hildenberg and Schlickau 2002; Narayanasamy, 2003; Leishman 2004). Results of this review indicated that cultural competence is a complex, multifaceted concept requiring practitioners to be on going learners and that the training systems need to develop proper measures that would help to educate cultural competent practitioners.

This literature review highlights some of the gaps and shortcomings in the evidence based on cultural competence in nursing. In the last few years the author of this study has read this work with great interest, but has been disappointed that nurse researchers have paid very little attention to how cultural competence could be integrated in the UK mental health nursing curriculum to educate nurses who can provide care that is both culturally appropriate and efficient to the diverse populations they will serve.

Firstly, despite the vast literature on cultural competence and the increasing reference for the need to integrate cultural competence training into the nurse education curriculum by nursing scholars (Leininger, 1995; Campinha-Bacote, 1999; Bhui et al, 2007), professional bodies (ENB, 1997, NMC, 2002; QAA, 2009) and the principles of social justice (Rawls, 1971; Douglas et al, 2009), agreeing exactly on what constitutes cultural competence has generated considerable debate and confusion. For example, ‘researchers have struggled with its definition and measurement’ (Balcazar et al, 2009, p.1153), suggesting that there is limited attention to what cultural competence actually means for educators or nurses and as such it is difficult to establish how cultural competence might be addressed within the training programs.

Secondly, a review of literature from cultural competence in nursing education and healthcare research strongly suggests that models, frameworks or workforce development programs for

cultural competence, by whatever name, contribute to meaningful understanding and should be a major component of health care education. However, despite the obvious potential of available models and workforce development programs for cultural competence, sadly there are several pitfalls to using these models and workforce development programs for cultural competence. For example, there is little empirical evidence to suggest that the available models and frameworks offer effective guidance for nurse educators to use when educating nurses to be cultural competent as their development omitted the perspective voices of nurse educators and nursing students who are the major players in the education process.

Another disappointment in the area is that most of the available models were developed primarily for the qualified nursing professionals working in clinical practice, not undergraduate nursing students in education setting. For example, to date, there has been no research that has developed a conceptual framework of training cultural competence within a UK context taking into consideration the perspectives of those involved in the undergraduate mental health nurse training such as nursing students and nurse educators. If conceptual frameworks of cultural competence reflect the context they were created in as discussed in the previous sections, it cannot be assumed that frameworks developed in other countries are applicable to nursing in a different country where the healthcare systems and cultural make up of the population including the history of migration of that population are different. This is mainly because the response of each country to have cultural competence models is in part dependent on the specific histories of immigration, and national attitudes towards immigrants, citizenship and how to address racial and cultural integration' (Bhui et al, 2007, p. 8).

Correspondingly, the context and the population used to develop that framework may have an impact on the intended audience where that framework is to be used. For instance, although questionable, if the framework is intended to be used to train mental health student nurses, the researcher feels that it should have been developed using the similar audiences such as student nurses and nurse educators. Arguably, there is a need to identify and develop conceptual frameworks that inform education curriculum that has the core components of cultural competence which are considered important when educating mental health student nurses to provide appropriate and effective care to the diverse population they will serve, in particular the United Kingdom's multicultural population. This study was partly undertaken to address these issues and to develop a conceptual framework of cultural competence that is relevant and applicable to the UK context.

## **2.8: Implications for the current study**

While the works of Campinha-Bacote (2002), Purnell and Paulanka (1998), Giger and Davidhizar (1999), Leininger (1995) and others are great contributions to the literature base as they used empirical methods to identify competencies, however, these works seem not to provide a context for understanding the experiences of student nurses and nurse educators who are directly involved in the nursing education. In particular, the literature review showed that nurse educators and student nurses' perspectives had been omitted in studies that developed the available cultural competence frameworks and models. Furthermore, with the exception of the Papadopoulos model for developing cultural competence, all the reviewed selected studies were mostly conducted outside UK and thereby were arguably found to be unnecessarily limiting, both in terms of developing theories that could be applicable in UK context and in terms of developing guidance for educators to use when educating mental health nurses to be cultural competent. The researcher felt the need to adopt a study approach based on the premise that key players' knowledge, experience and understanding about their own situation are essential components in shaping their own field.

Examining cultural competence from the perspectives of the neglected silent voices of the typical key participants who are directly involved in the undergraduate nurse training, specifically, student nurses and nurse educators contributes to the existing research in this area and provides a view not currently presented in the nursing literature. Thus the literature review was very useful as it provided justification for another study in this area and for the particular approach that was taken in this study.

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## **Chapter 3: Study Design and Methods**

### **3.0: Study design and methods overview**

This chapter describes and justifies the methodological and theoretical context and underpinnings of the current study which explored and examined how nurse educators and student nurses' experience cultural competence education within the undergraduate mental health nursing curriculum. The study used grounded theory research methods, with its theoretical foundations drawn from symbolic interactionism. The purpose of the study was to describe and conceptualize the strategies and processes involved when issues of cultural competence were addressed within the curriculum and to use the findings to develop an explanatory framework of these strategies and processes from the perspective of key participants involved in the undergraduate mental health nursing education within the UK context, specifically, student nurses and nurse educators. The chapter begins with a brief summary of the nature and origins of grounded theory and an explanation of the rationale for using grounded theory as the method of choice, followed by a discussion of the theoretical underpinnings of the study. To further discuss and defend the methodology, key premises of symbolic interactionism regarded as central to the current study are outlined as well as providing an analytic overview of the grounded theory approach used in the study. In setting the stage for discussion of issues involved during data collection and analysis, the chapter start by commenting on the role and position of the researcher in the research process. A detailed process of data collection and analysis is also given including relevant examples from the study, as well as the verification procedures conducted. Finally, this chapter demonstrates how issues of rigour and trustworthiness were addressed in this study.

### **3.1: Brief summary of the nature and origins of grounded theory used in the study**

In recognition to the need to educate nurses in ways that will enable them to provide care that is both efficient and culturally appropriate to the diverse populations, the current study aimed to describe and conceptualize the assumptions (in terms the nature, content and processes) of a culturally competence curriculum and to develop an explanatory framework of those processes and strategies. In an effort to explore and develop an explanatory conceptual framework from

those assumptions that are grounded in data collected from the perspective of those experienced in undergraduate mental health nursing education within the UK context, a qualitative grounded theory research design with its theoretical foundations drawn from symbolic interactionism was employed (Glaser and Strauss, 1967; Strauss and Corbin, 2008; Auerbach, 2003).

The grounded theory method of qualitative research employed in this study was originally developed by two sociologists, Barney Glaser who was initially trained in quantitative social research methods and Anselm Strauss who was trained in more qualitative research tradition (Glaser and Strauss, 1967). The significance of their combined differing perspectives in the grounded theory meant that they 'improved the theory research gap that had not been bridged by studies using deductive logical reasoning as the method of inquiry' (Jeon, 2004, p. 251). Grounded theory is mostly inductive, which means the researcher does not begin with a hypothesis about the phenomenon to be studied but instead remains open to whatever theory emerges from the data (Glaser and Strauss 1967, Strauss and Corbin 1990). In order to remain true to the inductive nature of the design, grounded theory has specific characteristics of project design, data collection and analysis, which will be explained later in this chapter. The theoretical underpinning of grounded theory in this study is informed by symbolic interactionism (Strauss and Corbin, 1990), as discussed in the next sections of this chapter. In addition, it has been claimed that researchers who use the grounded theory method try to integrate the strengths inherent in the quantitative method with the qualitative method (Walker and Myrick, 2006). Therefore, it could be argued that the qualitative grounded theory approach design used in this study has the capabilities of minimising debates about the ineffectiveness of qualitative research designs alone because the design used in this study has the ability to 'discover, develop and provisionally verify' its own findings (Strauss and Corbin, 1990, p. 23).

### **3.2: The theoretical underpinning of grounded theory used in the study**

The theoretical orientation of grounded theory approach used in this study is informed by ‘symbolic interactionism’ which was developed by Herbert Blumer (Blumer 1969, p. 79). Symbolic interactionism is a theoretical perspective relevant to qualitative research that focuses on human experience (Blumer, 1969). The focus of symbolic interactionism is on how people define events and realities and how they behave based on their beliefs (Blumer, 1969; Glaser and Strauss, 1967; Evans, 2001). In other words, symbolic interactionism focuses on the social aspects of human action and interaction, meaning, and interpretation of meaning (Licqurish and Seibold, 2011). In symbolic interactionism, participants are viewed as active participants whose actions and interactions are evolving in nature and influence each other to construct meanings based on their interpretations of their actions and interactions with themselves and others (Blumer 1969; Strauss and Corbin, 1990, 1994). Symbolic interactionists presume that someone’s sense of meaning is interpreted through social interactions, and the communication and understanding of verbal and non-verbal sociocultural symbols such as language (Licqurish and Seibold, 2011). Symbolic interactionism is ‘a worldview that provides a philosophical underpinning to grounded theory by providing the researcher with a set of sensitizing concepts’ (Milliken and Schreiber, 2012, p. 685).

With this theoretical orientation of grounded theory based on social interactionism in mind, the researcher wished to gain an understanding of the strategies and processes involved in the undergraduate nursing curriculum during the process of educating student nurses in ways that will enable them to provide care that is both efficient and culturally appropriate. This is also consistent with Blumer’s methodological position for symbolic interactionism, where he maintains that in order ‘to understand the world one must analyse it in terms of the participants’ actions and interactions in their natural context’ (Blumer, 1969, p. 39). Following Blumer’s methodological position, the researcher had to go and explore directly from the key participants involved in undergraduate nursing training at their places of education. The main purpose of the study was to identify how nurse educators and student nurses interpret their individual experiences and shared situations when issues of cultural competence are addressed in classrooms, what strategies and process that they took to achieve the desired outcomes as well as what obstacles they face and how they managed those obstacles in the curriculum. This is because one of the goals of symbolic interactionism is to understand the complex world of lived experience from the point of view of

those who live it (Blumer, 1969; Denzin and Lincoln, 2005). Therefore, in order for the researcher to attain a full understanding of the social processes involved within the curriculum when issues of cultural competence were addressed, the researcher needed to grasp the meanings that were experienced by the participants within the undergraduate mental health nursing training context as well as understanding the situation from the participants' points of view.

### **3.3: The rationale for using qualitative grounded theory design**

The choice of the grounded theory approach for the current study was driven by the research question, together with the consideration of the applicability and feasibility of the method in the context of the phenomena of interest. In the process of shaping, the research question through examination of the literature, it became clear that there was a paucity of studies exploring the undergraduate nursing education curricula in terms of how nurses could be educated in ways that will enable them to provide care that is both efficient and culturally appropriate. As only a few studies had explored the problem, there was a need for qualitative data in an attempt to arrive at a holistic understanding of the situation (Polit and Hungler, 1999; Holloway and Wheeler 2002). This is because a qualitative approach can provide an explanatory framework that explains the social world in situations where there are no strong theoretical bases to inform the practice (Guba and Lincoln, 1994; Morse and Field, 1995; Denzin and Lincoln, 2005).

The research question that guided the current study was: *What constitutes a curriculum to prepare mental health nurses to provide efficient and culturally appropriate care for the diverse populations that they will serve?* In considering the research question, the researcher concluded that it did not easily fit into the positivistic paradigm where the aim is to test existing theories or hypothesis by placing emphasis on measurements and explanations (Guba and Lincoln, 1994). The goal of this study was not to test or verify existing theories or hypotheses, but to develop a conceptual explanatory framework, which can help educators to educate student nurses in ways that will enable them to provide care that is both efficient and culturally appropriate to diverse communities. To achieve this goal in this current study, the researcher explored and examined the assumptions, experiences and perceptions of the key participants involved in the undergraduate mental health nurse training.

Secondly, the choice of a qualitative grounded theory approach design was appropriate to this study's aim of developing an explanatory framework of those assumptions from the perspective of those experienced in undergraduate nursing education within the UK context. This is because grounded theory principles emphasise the understanding of participants' voices to systematically develop a theory or conceptual framework about phenomena through individuals' account of their experiences (Glaser and Strauss, 1967; Glaser, 1978; Strauss, 1987; Strauss and Corbin, 1998). For instance, when the researcher first thought about study design, he planned the study from a value position in holding that people experiencing the phenomena under study are abundant in resources of their experiences which they bring to the situations and are deeply influenced by their life experiences. Therefore, in order to understand the meanings through which individuals interact and construct their worlds requires an emic research perspective (Milliken and Schreiber, 2012). According to Milliken and Schreiber (2012), an emic research perspective requires the researcher 'to enter the everyday worlds of participants to learn the experiences of those living there' (Milliken and Schreiber, 2012, p. 687). In this way, the researcher undertook an internal dialogue between and among his own perspectives and the perspectives of the participants until the understanding became clear. Consequently, the researcher, mirroring the role of participants, engages in an internal dialectical process from which he formulates a framework to explain the situation and its resolution. From the perspective of symbolic interactionism, this internal dialogue is known as 'minded behaviour' (Milliken and Schreiber, 2012, p. 688).

Additionally, the researcher believed studies previously omitting the voices of those directly involved on the phenomenon such as mental health student nurses and clinical educators in have left a void in cultural competence research. Including such omitted voices, for instance learners' voices, contrasts with the view often implicitly held, that learners are 'empty vessels' to be filled until they are in a position to work within the arena that is created for them (Brockbank and McGill, 1998). Furthermore, collecting the data from participants in the natural field permitted the researcher to immerse himself in the phenomenon and understood the meaning of the phenomenon from the perspective of those participants in terms of how they lived the phenomenon and how they perceived the phenomenon in the way they acted.

The qualitative grounded theory approach design was highly appropriate for this study as the study aimed to discover how the key participants involved in the undergraduate mental health nursing education resolve their main concerns as they explained and confirmed patterns of behaviour that were problematic and relevant to them. Therefore a qualitative grounded theory

approach facilitated the process of discovery, conceptual framework development and verification of the experiences being investigated as they occurred for the study participants (Glaser, 1978; Strauss and Corbin, 1990).

One of the aims of a grounded theory research is to develop substantive or formal theory (Glaser and Strauss, 1967), and thus a means of explaining social processes of an explanatory framework. Likewise, symbolic interactionism is one of the interpretivist perspectives in research that depicts the understanding of meaning making (Denzin and Lincoln, 2005) and ‘provides a theory that explores human behaviour’ (Aldiabat and Le Navenec, 2011, p. 1068). This is because ‘meaning’ is considered as one of the major elements in understanding human behaviour, interactions and social processes by symbolic interactionists (Jeon, 2004, p. 250). This is consistent with Blumer’s premises of symbolic interactionism which upholds that ‘meaning is a social product made possible through social interaction with others’ (Blumer, 1968, p. 2).

Guided by the premises of ‘symbolic interactionism in terms of the meaning making’, the researcher explored the meanings participants assign to the words they choose, so that the researcher did not impose his own meanings onto their intents. For example, this was achieved by occasionally, re-contacting some of the participants to seek such clarification at a later time following the interviews. This was pre-empted at the end of each of the interview questions which stated that: *“If it is necessary, may I contact you again to seek further clarification on what we have discussed today?”* [See appendices 1, 2 and 3 for example].

Symbolic interactionism was also utilised in this study by the researcher when he actively interacted with the study participants and saw their experiences from their point of view in their natural settings of higher education institutions. Therefore, it witnessed the processes used in the curriculum focused on educating student nurses in ways that will enable them to provide care that is both efficient and culturally appropriate. Therefore, symbolic interactionism was central to the current study as it allowed the researcher to explain rather merely describe the processes and strategies used by study participants to achieve a cultural competence inclusive curriculum including the impacting variables.

Finally, one of the advantages of employing grounded theory approach is that the method diverges from some other qualitative methods by incorporating perspectives beyond those of participants per se (Milliken and Schreiber, 2012). For example, using the grounded theory principles in this

study, the researcher gained an understanding of the participants' perspective of the phenomenon under study and he also brought in other points of view, including observations, sensitizing concepts, and material gleaned from related literature and other curricula documents, to enrich the emerging theoretical constructs (conceptualizations).

### **3.4: Overview of the role and position of the researcher in the whole research process**

The aims of the study were to describe and conceptualize the strategies and processes involved when issues of cultural competence were addressed within the curriculum and to use the findings to develop an explanatory framework of these strategies and processes. From the aims of the research, this research could be considered as an example of culturally competent research. According to Papadopoulos (2006), a culturally competent research is defined 'as research that both utilizes and develops knowledge and skills which promote the delivery of health care that is sensitive and appropriate to individuals' needs, whatever their cultural back' (Papadopoulos, 2006, p. 85). As a result, the researcher of this study adopted the constructs used the model for the development of culturally competent researchers proposed by Papadopoulos (2006). However, this section will not necessarily discuss those suggested concepts in order as they were proposed by Papadopoulos (2006), as some of those constructs seem to overlap. This section is aimed at commenting on the role of the researcher in this study as a way of setting the stage for discussion of issues involved during data collection and analysis. The section includes researcher's background information and experiences that could have shaped the whole study. The section also identifies reflexively the researcher's biases that could have shaped the interpretation formed during the study including how the theoretical sensitivity was employed as a way of minimising some of the possible biases.

### **3.4.1: Researcher's background information and experiences**

This research study was part of the PHD study and was wholly conducted by a single researcher with guidance, advice and supervision from a team of two academic supervisors. The researcher was a male in his late thirties and from an African background. The researcher is a dually qualified mental health nurse and a general nurse who had extensive experience of working in many specialties of nursing and in middle nurse management roles. The researcher also holds a professional law qualification. The researcher is also a qualified further education lecturer holding Certificate in Education with Qualified Teacher Status. Academically the researcher at the time of doing the research, his highest qualification was a Masters Degree in Public Health. In terms of researching experience, the researcher had been involved in participating in clinical trials during his nursing practice and also holds a Post Graduate Certificate in Research Methods. The researcher has also been involved in assessing and mentoring student nurses during their clinical placements and at times was involved in directly teaching them as a visiting lecturer. Such experiences and exposures meant that the researcher did not come to do this research study with an empty head about the phenomenon and the population under study but, his background could have some potential of influencing the whole research process.

### **3.4.2: Researcher's Reflexivity**

Some research studies tend to omit the reflexivity of researchers in their studies possibly because reflexivity is often misunderstood as a confession by the researcher of being non objective and non neutral when conducting their studies (Nightingale and Cromby, 1999; Willig, 2001). Nightingale and Cromby (1999) urge researchers to explore their 'reflexivity' as they stress that 'reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining outside of one's subject matter while conducting research' (Nightingale and Cromby, 1999, p. 228). Some researchers have come to a conclusion that the research study is never complete until it includes an understanding of the active role of the researcher's self which is exercised throughout the research process (Leininger, 1995; Nightingale and Cromby, 1999; Papadopoulos, 2006). To



increase credibility of the study, the researcher reflected upon the ways in which his own values, experiences, interests, beliefs, social identities, wider aims in life could have shaped the study.

In this study, using the principles of grounded theory as the qualitative strategy of inquiry, data collection and analysis was conducted concurrently with each stage informing the other. The researcher did not go into the field of research with an empty head and the audio recorder to record the facts, but as a human being complete with all the usual assembly of feelings, failings, and moods. As the researcher was both the data collection and an analytic tool, the questions of bias are hard to eliminate as the researcher's personal histories, his lived experiences, his education and his culture could have had an impact. For example, the researcher being from an African origin, the issue and effect of prevalent cultural values is hard to completely eliminate especially in the interpretation of qualitative data. This is because nature has it that the interpretation of the meaning of any given 'fact' is determined by the interpreter's cultural values. For example, Papadopoulos (2006) points out that, 'we all hold cultural values and cultural biases and can be ethnocentric' (p. 87). As a result, the researcher would like to acknowledge that the research and researcher were not necessarily value free, and as a result the researcher could scarcely dissociate himself from his value commitments in pursuing his professional ends (i.e to complete his PHD in time). This was demonstrated when during the end of the data collection process, it emerged that the clinical sign off mentors and clinical mentors were also part of the teaching team and needed to be included in the data sets. The researcher attempted to include them, however when the response was slow and time was running out, he only ended up recruiting a total of four that were used in this study. Furthermore, it should be noted that as human beings, we tend to react to theories which aim to predict our actions; therefore readers are urged to consider these and make their sense of the findings, discussions and conclusions.

Because unconsciously, the researcher was likely to have some biases, values, interests, predictions, experiences and characteristics that could have shaped the research and its outcomes, therefore the researcher would like to alert the readers of possible influencing factors. Field work requires imagination and creativity and as such, the researcher encountered some fieldwork that was extremely cumbersome and challenging. For example, some of the participants that were interviewed by the researcher could have acted in response to the researcher's presences or could have responded to satisfy what they believed the researcher wanted to hear. This could be true because of the fact that the researcher was an African and enquiring about how the care needs of the marginalised population could be addressed within the curricula. This could be misunderstood

as inquiring [the researcher] to have his fellow minority groups including himself be given priority within nursing. For example, in one of the interviews, a senior lecturer from a White British background gave this comment:

*“of course I really appreciate and understand the concerns in your research, probably from experience and encounters you or your colleagues, relatives friends might have had a bad experience from the care given by nurses, however, realistically, we’re doing what we’re doing within the best of our abilities to try to address the issues of diversity within our teaching, however, there’s also a question of whether we ourselves are competent to deliver the expectations ..... I mean whether our system has the necessary support for lecturers to deliver this.” [SL3].*

Although the senior lecturer referred to the care given to the researcher and his ethnic minority colleagues, the researcher was not seeking to elicit such responses. At the same time the senior lecturer volunteered the information that the university was not well supporting senior lecturers when it comes to teaching cultural diversity issues within the curriculum. Such emergent issues which initially were not in the interview guides were incorporated at this stage. However, the researcher wondered whether this information would have been so readily revealed to a white researcher. Certainly, the researcher thought that his ethnic background gained him access to information that might not have been given so willingly to a differently positioned white researcher. Such assumptions are also supported by researchers going back more than two decades such as Hastrup (1992) who suggest that researchers are positioned by characteristics such as age, gender, sexuality, ethnicity, identity, and so on, all of which may inhibit or enable certain research method insights in the field.

The researcher had to admit that there were occasions in some interviews when he listened sympathetically to the participants about how issues of cultural competence have caused some concerns within the curriculum, especially when study participants gave emotional statements such as *“....if they aren’t prepared to provide proper care to them, so why invite them in the first place....”[S1FG2]*. At the same time, there were also some occasions when the researcher listened angrily to the interviews from the study participants when they gave statements such as *“... we did not come to the university to learn about providing excellent nursing care to foreigners ....” [SN7]*.

However, in both occasions, the researcher was assessing and synthesizing on how the participant’s words and voices could be made great quotes for the researcher’s study. At times the

researcher discussed such issues with his supervisors who debriefed him and suggested future approaches in similar situations, which the researcher found very useful.

### **3.4.3: Researcher's theoretical sensitivity**

In an attempt to deal with issues of reflexivity, before commencing the data collection and analysis, the researcher's personal qualities were guided by the theoretical sensitivity principles also known by some cultural competence experts as cultural sensitivity (Papadopoulos, 2006). Theoretical sensitivity according to Strauss and Corbin (1990) refers to 'the attribute of having insight, the ability to give meaning to data the capacity to understand, and capability to separate the pertinent from that which is not' (Strauss and Corbin, 1990, p. 41). The researcher's theoretical sensitivity was based on the literature read, his professional and personal experience.

At the beginning of the study, the researcher undertook a review of the literature relating to the concepts of cultural competence and culturally competent care. This could be viewed as contrary to some traditional approaches to grounded theory where a literature review is avoided before collecting data with the belief that the inductive nature of process will be influenced by the researcher's preconceptions about the area of study (Glaser and Strauss 1967, Clarke 2005). However, some contemporary grounded theorists, such as Charmaz (2006) and Clarke (2005) recommended a literature review as essential for establishing where the proposed study fits in the context of what is already known. Therefore, the review of the literature in this study informed the research proposal, in terms of the research question. The research question was: '*What constitutes a curriculum to prepare mental health nurses to provide efficient and culturally appropriate care for the diverse populations that they will serve?*' Further review of the literature occurred as a result of data collection and analysis as detailed in the discussion chapter of this study.

The researcher read the related evidence around the phenomenon to be studied in order to sensitize him to what was going on with the phenomena being studied and any supporting evidence for conducting the study. Further, as the researcher is a qualified nurse, the researcher therefore drew up the rich knowledge base and insights available from his professional and personal experiences. While drawing his knowledge base and insights from his professional and

personal experiences, the researcher was quite careful to remain open and aware of things that have become routine or obvious including avoiding assumptions that people's experiences were similar.

Throughout the data collection and analysis, the researcher focused on discovering different variations through constant interaction with the data and always questioning with the data. The researcher was sensitive on the inclusion and exclusion criteria for research participants. Based on the advice given by the research supervisor in terms of feasibility of time, distance and resources available to the researcher, it was decided to target only the Universities in West Midlands region. During data collection phases, the researcher ensured that the questions asked were relevant to the target audience and tried to make sure that questions asked did not offend respondents. The researcher admits that there was one time when during the focus group some of the participants appeared to be offended by the discussions and the researcher had to stop the focus activity. The researcher then went for debriefing with his supervisors who suggested the minor changes to some questions that were considered offending, inappropriate or insensitive. After doing those amendments, successive focus groups went on well.

The researcher used constant comparative process of defining and redefining any emerging themes in the light of new data (Papadopoulos, 2006, p.95) In order for the researcher not to deviate much from the data when interpreting the data, the researcher used the participants' own words (excerpts) from the transcribed data. Constant comparative process was also used to look for interactions between data, between different sources of information and between different times. By being theoretically sensitive, the researcher periodically stepped back and asked himself what was going on with the data and whether his thoughts and understanding did fit with the data. The researcher maintained an attitude of reflection and scepticism by being his own critic. For example, the researcher in interpreting the data considered whether interpretations opposite to his own could be made with the same data. In addition, the researcher validated his data through triangulation using different sources such as interviews focus, curriculum materials and respondent validation as well as asking feedback from the participants at the end of interviews and asking them to confirm the summaries, sometimes emailing the findings to some of the participants to confirm. For example, the preliminary findings were taken to the research

supervisors and also some Call for Papers conferences within the university which provided feedback, reflection, comments for improvements and validation were conducted. It was also the theoretical sensitivity that allowed the researcher to develop themes and theoretical constructs that were grounded, conceptually dense, and well integrated using the analytic processes discussed in the findings chapter.

Additionally, when analyzing the data, the researcher tried to use the participants' textual statements as ideas (concepts) and where the researcher made his own interpretation, he tried to explain his base of such interpretation using the participants repeated ideas in their own wording. At the end of the data analysis, before the writing of the final draft, the researcher took back the data to the participants to verify the data and make comments and compliments. The intent of using the participants' excerpts and taking back the final draft for verification were to minimize appropriation by avoiding misrepresentation that could occur between the researcher and the study participants.

Although the researcher made some revisions of the final draft as a result of the verification with the participants, it could be argued that the final text that was published is still the final construct of the researcher and that it was the researcher who ultimately chose which quotes and whose voices to include. The researcher strongly believe that as a researcher, he needed to be more open and honest about his research and the limitations involved and therefore the reasons why he provided his role within this research study and how his role consciously or unconsciously could have influenced his study.

### **3.5: Application of the current study methodology**

This subsection discusses the application of the current study methodology in terms of setting, participants and sampling, data sources, data collection instrument, ethical considerations and so on.

#### **3.5.1: Setting**

The sample participants for this study were drawn from the seven universities that offer pre-registration mental health nurse training in West Midlands region. The West Midlands region was chosen for this study because it is a diverse and vibrant region that has the unique benefit of being located at the heart of the UK with diverse population in terms of ethnic mix, as well as the added advantage of having easily accessible universities located in both urban and rural settings. The rationale behind choosing the participants from both rural and urban settings of the West Midlands region was based on the researcher's assumptions that there could be differences in experiences and attitudes among participants from urban and rural settings towards the ways they view the nursing care needs of diverse cultures based on their socio-environmental influences. In addition, research study from Lasala (2000) seem to suggest that nursing staff from urban and rural settings approach cultural care issues differently for unknown reasons. Therefore, the researcher was aiming to explore the reasons why individuals from urban and rural settings approach issues of culture differently.

### **3.5.2: Participants and sampling**

In consistent with the grounded theory approach, the study participants were not recruited on a representative basis, but because they were thought to be most likely to have sufficient knowledge and experience related to the topic of study. In fact, at the start of the study, the researcher selected student nurses and nurse educators from the universities that offer undergraduate nursing education in the West Midlands health region of the UK as participants because they were considered to be the ones closely experiencing the phenomenon under inquiry. In particular, mental health student nurses and nurse educators were selected because the reviewed literature suggested that nursing students as well as professional nurses and in particular mental health nurses are not ready to meet the challenges posed by an increasingly culturally diverse society (Rodriguez, 1997; Hildenberg and Schlickau, 2002; Kirmayer, 2002; Sainsbury Centre for Mental Health, 2002; Department of Health, 2003; Leishman, 2004; Sealey et al, 2006). Furthermore, some literature suggested that the problems emanates from the way issues of cultural competence are addressed by educators during nurse training (Leininger, 1994; Gerrish and Papadopoulos, 1999).

In accordance with the principles of grounded theory methodology (Glaser, 1978), the purposive sampling techniques were initially used to recruit participants for this study. Bogdan and Biklen (1998) describe purposeful sampling as choosing ‘particular subjects to include because they are believed to facilitate the expansion of the developing theory’ (p. 65).

Since the purpose of the study was to develop a conceptual framework of developing cultural competence from the from the perspectives of the key participants involved in the undergraduate nursing education, participants in this study included individuals who had been identified as having been experienced in the instructional system and learning milieu of undergraduate mental health nursing education. The procedure of how the participants were contacted and recruited is discussed in section 3.5.7 of this study.

The key participants within the instructional system (nurse educators) of the sample were initially limited to senior lecturers, principal lecturers and award leaders. Senior lecturers who participated

in the study reported many years of experience both as registered mental health nurses and as senior lecturers within their respective universities.

As the research progressed, theoretical sampling was used to recruit further study participants from the instructional system. For example, as the subsequent data were collected and analysed, the emerging themes indicated that there might be merit in increasing the differences of the data sources in the sample. The preliminary findings pointed towards the desirability of expanding the sample to include student sign-off mentors and student clinical mentors linked to the relevant universities as it emerged that they were also part of the training process of mental health nurses. Accordingly, two student clinical mentors and two sign-off mentors for students were included in the study sample.

A “clinical mentor” is a registered qualified nurse who has a duty to facilitate students of nursing and midwifery to develop their clinical competence (NMC, 2008). A “clinical sign-off mentor” is a mentor that the university in collaboration with the student clinical placement make the decision about the student's fitness for practice under the Nursing and Midwifery Council (NMC) guidelines (NMC, 2008). The nurse who is a clinical sign-off mentor makes the decision about a student's practice proficiency to register as a qualified nurse at the end of their training. This therefore, suggests that clinical mentors and clinical sign-off mentors were in very better positions to comment on students’ preparedness to work in practice as a qualified nurse and in terms of what cultural care issues need to be part of the curriculum.

Clinical mentors and student clinical sign-off mentors also reported many years of experience as registered nurses and their experiences ranges from five years to thirty three years. However, the clinical-sign off mentors reported that they have just been in that position for less than two years despite some of them reporting that they have been involved in assessing nursing students for more than five years.

Consequently the key participants within the learning milieu (student nurses) of the sample were limited to the third year mental health nursing students. In the learning milieu, participants were limited to students in their final year of study on the assumption that they were most likely to have sufficient knowledge and experience related to the topic of study and that they might assess the



entirety of their mental health nurse training experiences as they were in the better position to evaluate their preparedness for practice at the completion of their nurse training.

Involving student nurses' voices and perspectives about their education experiences when cultural competence issues are discussed in classroom environment are relatively new growing field of inquiry. This kind of inquiry is especially significant in cultural competence inclusive curricula because of the inherent growing need of student-centred learning environment expected in modern contemporary education methodologies (Kember, 2009; Armstrong, 2012). Student-centred learning is defined as an approach to education focusing on the needs of the students, rather than those of others involved in the educational process, such as nurse educators, curriculum developers and other course administrators. For instance, Armstrong (2012) claimed that 'traditional education ignores or suppresses learner responsibility (Armstrong, 2012, p.2). In other words, Armstrong (2012) is suggesting that the student should take responsibility for their learning rather than having teacher-centered approach which he claims to reduce learner responsibility. Thus listening to what nursing students have to say about their experiences and attending to their suggestions can result in a more critical conception of cultural competence education. Likewise, students' views have important implications for transforming curriculum and pedagogy and for educational reform in general. The researcher is not advocating that the nursing students' views should be adopted uncritically. What the researcher is suggesting instead is that, if nursing students' views are sought through a critical and problem solving approach as suggested by Ladson-Billing and Gilborn (2004), their insights could be crucial for developing meaningful, liberating and engaging educational experiences. In essence, nurse educators may miss a powerful opportunity to learn from the nursing students when student voices are omitted in any educational framework of teaching.

In addition, the obstacles and challenges to learning cultural competence in a classroom environment can be missed if students' perspectives are omitted. For example, in this study, nursing students were questions such as: *What are some of the obstacles and challenges to learning cultural competence do you face in your studies?* Consequently, this current study has sought nursing students' views rather than relying on experts (educators) alone to inform the development of a conceptual framework of teaching cultural competence. For example, in this study, students were also asked questions on how they felt about the curriculum they learn in terms of cultural competence issues. [*How do you feel about the curriculum you learn in terms of preparing you to provide care to patients from different backgrounds?*]. [*What do you think about*

*the pedagogical strategies of your lecturers?*]. Although these could be considered as the key questions that could affect cultural competence learning of students, no models reviewed on cultural competence literature have given student voices and the opportunities to discuss them. The researcher of this study felt that focusing on nursing student views might have some great deal as students might give a feeling about the pedagogy they experience of which they did in this current study.

In this study, the sample size was not fixed, but it ideally relied on theoretical sampling as suggested by Glaser (1978). Theoretical sampling according to Glaser is seen as ‘the process of data collection for generating theory or framework whereby the analyst jointly collects, codes, and analyzes his or her data and decides what data to collect next and where to find the data, in order to develop his/her theory as it emerges’ (Glaser, 1967, p. 45). In this study, the theoretical sampling was guided by the emerging themes and categories especially where there was the need for study participants to further elaborate those themes and categories from the previous analysed data.

The final sample of this study had twenty nine participants, which included nine senior lecturers, two clinical mentors, two sign-off clinical mentors and seven student nurses who participated in one to one interviews, as well as nine student nurses who participated in two different focus groups (see table 1 below). All the participants in this study composed of both males and females from different ethnic and cultural backgrounds. In line with the principles of grounded theory, the final sample size of this study was based on judgement when concurrent data collection and analysis suggested theoretical saturation (Glaser and Strauss, 1967). In other words, the data collection and analysis in this study continued until exploring further data did not add to the insight already gained or when ‘no new properties emerged and the same properties continually emerged’ in the collected data (Glaser, 1978, p. 53).

**Table 1: Used data type and source including demographic data of participants**

<b>Type/Source of data</b>	<b>Total participants</b>	<b>Males</b>	<b>Females</b>	<b>White British</b>	<b>Black and minority ethnic</b>
<b>1-1 interviews with Senior Lecturers [SL]</b>	<b>9</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>3</b>
<b>1-1 interviews with Student Nurses [SN]</b>	<b>7</b>	<b>3</b>	<b>4</b>	<b>2</b>	<b>5</b>
<b>1-1 interviews with Clinical Mentors [CM]</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>
<b>1-1 interviews with Clinical Sign-off Mentors [CSM]</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>
<b>Student Focus Group 1 Interviews [SFG1]</b>	<b>3 in focus</b>	<b>0 in focus</b>	<b>3 in focus</b>	<b>1 in focus</b>	<b>2 in focus</b>
<b>Student Focus Group 2 interviews [SFG2]</b>	<b>6 in focus</b>	<b>2 in focus</b>	<b>4 in focus</b>	<b>2 in focus</b>	<b>4 in focus</b>
<b>Total no. participants</b>	<b>29</b>	<b>11</b>	<b>18</b>	<b>13</b>	<b>16</b>
<b>Total 1-1 interviews</b>	<b>20 interviews</b>	<b>9</b>	<b>11</b>	<b>10</b>	<b>10</b>
<b>Total focus groups interviews</b>	<b>2 focus groups</b>	<b>2</b>	<b>7</b>	<b>3</b>	<b>6</b>
<b>Curricula materials collected</b>	<b>4 module guides</b>	<b>3 PowerPoint handouts</b>	<b>2 guidelines</b>	<b>2 reference materials</b>	

### **3.5.3: Data Sources**

The primary data sources for this study included the individual interviews with senior lecturers, third year mental health student nurses, student clinical mentors and student clinical sign-off mentors, as well as focus groups with student nurses. One to one interviews were focused on gathering information about individual participants' understanding of cultural competence and how they prefer such issues to be addressed including some of the strategies that are used when addressing such issues. Focus groups were focused on gathering group feelings when issues of cultural competence were being addressed. Furthermore, focus groups were targeted to the students who could possibly have not had a chance to attend one to one interviews. In addition to interviews, the secondary source of data was the curriculum documentation materials such as module guides, lesson plans and handouts used during delivery of cultural competence programs within the curriculum. Curriculum documentation materials were coded separately from interview data and provided a means to confirm and validate information from study participants. Different data sources were used to substantiate each other and using more than one data source was a form of triangulation which is believed to increase the trustworthiness of inquires (Hek and Moule, 2006). Additional information on how the data was used to substantiate each other and how triangulation was utilised will be provided later in this chapter.

### 3.5.4: Data collection instrument - interview guides

At the start of the study, it was concluded by the researcher that some structure was necessary to assist and give focus to the data collection process in terms of making sure that specific set of topics and themes were covered in the interviews. As a result, three main semi-structured interviewing formats were devised: one for senior lectures (see appendix 1), one for student nurses (see appendix 2) and one combining clinical student mentors and student clinical sign-off mentors (appendix 3). These interviewing guides were devised in the order to allow the flexibility to explore perceptions and views expressed by participants, in the context of a reflexive conversation with the researcher.

The interview guides were devised based around the reviewed literature and they contained questions that provided a loose contextual framework upon which to build further inquiry. Such loose contextual questions include; “*How would you prefer such issues to be discussed within the curriculum.*” (See appendices 1, 2 and 3 for examples of questions). The rationale for using such loose contextual framework questioning was to guide interviews in a focused, nonthreatening open manner that facilitated open discussions.

While initial interviews began with a set of simple prompts based on the reviewed literature, the interview guides went through changes at specific points during data collection and analysis as new information emerged. For example, using a constant comparative process, early in the focus group interview sessions with student nurses, the need to have cultural competence specific modules emerged as an important factor that was suggested as an encouragement for students to take the module seriously and subsequent interview guides were expanded to explore this area further. The questions that were asked include: *Imagine once again that you were the lecturer on this course; can you think of other ways of designing the course/programme in order to prepare student nurses for work with diverse population? Will you do anything differently?*

The interview guides were also constantly revised at different stages to accommodate participants’ direction and according to emerging themes. The revision of interview guides over specific stages highlighted the inductive and emergent nature of the research design used in this study (Glaser, 1978). The interview guides comprised of a place to write summaries of the main findings or

discussions during or immediately after the interviews. Such an approach was used as a way of confirming with the participants about the main findings or points raised during the interviews so that the participants' could comment or change their statements before the data was transcribed. Data collected from these interviews were audio taped then later transcribed verbatim.

### **3.5.5: Conducting the pilot study**

As it was likely that the first drafts of interview guides may need modifications, the researcher sought to improve rigor and trustworthiness of the first drafts interview guides by testing out with colleagues, subject experts and research supervisors before there were used in the final data collection. Two draft versions of the interview guides devised based around literature were piloted with the small numbers of participants from student nurses and qualified mental health nurses to test draft interview questions and to provide further interviewing practice to the researcher. The interviews were piloted using one qualified nurse who was also working as a visiting mental health lecturer at one of the universities that participated in the study and one third year mental health student nurse from also one of the participating universities. The participants selected for the pilot study were broadly representative of the type of participants for the final study. In addition, conducting the pilot interviews allowed the researcher to receive feedback on interviewing skills and the interview format.

Following this pilot stage, a few minor refinements were made to the draft interview guides, mainly in the phrasing of some questions that were considered unclear or ambiguous by the pilot participants. For example, following the pilot study interviews with one of the qualified nurse who was also a visiting mental health lecturer, the phrasing of the interview question was refined and changed from being a directive question to an explorative interview question. For instance, the initial question before the pilot with the visiting nurse educator was:

*What are the main issues you as a nurse educator focus on when designing the curriculum?*

The visiting nurse educator said she actually does not design the curriculum, but if she has the opportunity, she would consider focusing on a number of issues. Following the pilot study with

the visiting nurse educator, the researcher discovered that the question was too directive and suggested that not all the nurse educators design the curricula. As a result of this pilot study, the interview question was rephrased to:

*What do you consider to be the main issues that nurse educators should be focussing on when designing the courses to prepare students for work with diverse population?*

Similarly, before the pilot study with nursing students, one of the original questions was:

*Are you happy with the content of how cultural care issues are addressed within the curriculum?*

The response to such a question was “no, I am not happy” and nothing else. Following the same pilot study with the nursing students, the interview question was rephrased to:

*Coming back to how the nursing care needs of the diverse population were addressed within the curriculum, what do you think about the content?*

The piloted interview guides were then given to the researcher’s supervisors who also suggested some minor modifications and refinements such as adding some prompts. Additional corrections, revisions and adjustments were done to the interview guides as part of being subjected to the researcher’s colleagues and wife who is also a qualified senior nurse. Since some significant minor changes and refinements were made to the draft interview questions therefore, the pilot interviews data was not included in final analyses of the study. However, the pilot study gave the researcher more confidence to pursue with the main study.

### **3.5.6: Ethical considerations**

Ethical approval was obtained from the University of Wolverhampton Sub Research Ethics Committee and the study was conducted in accordance with the University's requirements. Prior to the initial interviews, written and verbal information was given to the participants about the purpose and nature of the study, emphasising that participation was voluntary, as well as guaranteeing confidentiality. Participants were also reminded that the study was approved by the University of Wolverhampton Sub Research Ethics Committee (see appendix 12). During the initial interviews, participants were asked to sign an informed consent that again outlined what was involved in participation in the study. The informed consent form also stated that the study was voluntary and that individuals could discontinue participation at any time. The researcher of this study offered the participating institutions the outright to refuse participation (see appendices 4 to 9). As a result, some clinical placement managers opted to have their nurse educators from the clinical side not to participate citing increased workloads. Additionally, participants were given pseudonyms to ensure privacy when reporting on data. Ethics of actual study are fully discussed in later sections of this study.

### **3.5.7: Procedure for recruiting participants**

All the seven universities that offer undergraduate mental health nursing education in West Midlands Health region were targeted for participation. Potential participants were identified through faculty offices' allocation departments for individual universities. Identification of potential participants was approached in stages. In the first stage, in order for the researcher to access the nurse educators and student nurses, permission was needed from the Dean of Faculties. The researcher wrote letters and asked for permission to conduct the study from the Deans of Faculties of each of the selected universities in West Midlands region. The Deans were considered to be the gatekeepers or people in power as they were considered to be the ones safeguarding the



interest of nurse educators and student nurses within their nursing faculties (Evans and Pearson, 2001). Each Dean of Faculty was given a copy of the research proposal so that they were aware of the main purpose of the research study and inclusion and exclusion criteria (see appendix 5).

After being granted the relevant permission from the Deans of Faculties, the researcher contacted the faculty of mental health nursing offices to be given the contact details of the educators (senior lecturers) involved in the delivery of the curriculum. Initial contact was made through a formal introductory letter which outlined the purpose of study, and invited participation in the study (see nurse educator participant invitation letter and information sheet in appendix 6). The letters also detailed the confidentiality of the interviews, and that the study was approved by the University of Wolverhampton Sub Research Ethics Committee. The senior lecturers participants were informed that their names were obtained from the faculty office after the permission was granted by their respective Dean of Faculty and that their decision to participate was voluntary. If there was no response, the initial letter was followed- up by email or by a second letter until the target number of sample subjects was achieved. No nurse educator participant was contacted more than twice if they failed to respond. Most of those who agreed to take part did so by letter or email, with only a couple of them who did so by telephone. Copies of these correspondences were kept and maintained as a testimonial of written consent. Some of the senior lecturers who were contacted agreed to participate and interview dates, times and places were established.

During the initial interviews, participants were asked to sign an informed consent form that again outlined what was involved in participation in the project. The informed consent explained that the study was voluntary and that individuals could discontinue participation at any time (See Appendix 9 for a copy of informed consent). In addition, after the interviews with senior lecturers, the researcher asked them for their favours to distribute invitation letters; information sheets and consent forms to the third year mental health student nurses and also to arrange one to one and focus group interviews with student nurses (see appendix 7, 8 and 9). Some of the students responded to the researcher directly as they had the contact details of the researcher on the information sheet, saying that they wished to participate in one to one interviews and the times, place and dates were which were convenient were agreed. Some groups of students made arrangements with their lecturers to attend the focus group meetings and the respective lecturers contacted the researcher to agree on the date, venue and time.

Later in the interview sessions with senior lecturers, it emerged that clinical student sign-off mentors and clinical mentors were also considered to be part of the clinical teaching staff and this group was then recruited including expanding subsequent interview guides to explore this area further (see appendix 3).

The researcher then contacted the Faculty offices to be given the names of the clinical teaching staff which included clinical student sign-off mentors and clinical mentors. The researcher wrote and phoned some of the clinical educators inviting them to participate in the research study (see appendix 6). The nature of the research was also explained to the clinical educators so that an informed decision about participation could be made. These participants were also informed that their names were obtained from the faculty office after the permission was granted by the Deans of Faculty and that their decision to participate was voluntary. Having contacted clinical educators on three different occasions using two separate methods (phone calls, writing); it was assumed that they had made a decision not to participate in the research. Four of the clinical educators who were contacted agreed to participate and an interview time and place were established.

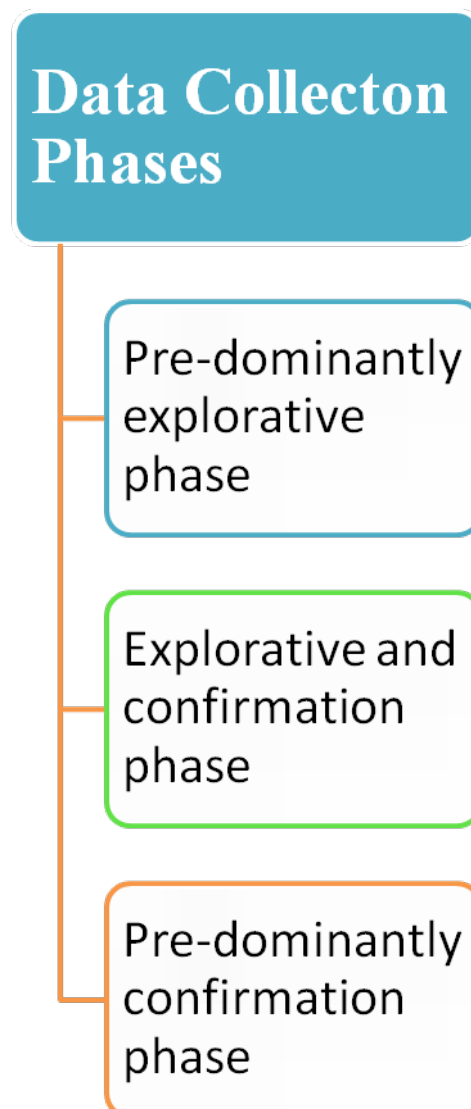
### **3.6: Data collection overview**

In studies that utilise the grounded theory approaches in their research, the data may be collected from interviews alone (Canales and Bowers, 2001), individual and focus group interviews (Charleston and Happell, 2006), interviews and document analysis (Coyne and Cowley, 2006) or from a combination of these sources (Romanello, 2007). In this study, individual interviews and focus groups were selected as the main data collection tool. The data were derived from semi structured interviews with nine senior lecturers, seven third year mental health student nurses, two clinical mentors, two clinical sign-off mentors, as well as two different focus groups of third year mental health student nurses. In general, the nurse educators (senior lecturers, clinical mentors and clinical sign off mentors) were interviewed individually while the nursing students were interviewed either individually or in focus groups, as well as in individual interviews followed by focus groups depending on their choices.

In addition, some of the data were derived from observing the curriculum documents used (such as lesson plans, syllabuses, handouts) and literature, see Table 1. However, the bulk of the data that resulted in the development of the proposed conceptual framework of developing cultural competence were derived from interviews with participants. Throughout the study, the researcher audio-recorded the interviews with participant consent, as well as keeping a reflection diary of the interviews and other observed curriculum documents.

Guided by the principles of grounded theory (Glaser and Strauss 1967, Glaser 1978; Strauss and Corbin, 1990; 2008; Chiovitti and Piran, 2003), the study comprised of three main phases of data collection namely: the predominantly explorative phase, the explorative and confirmation phase and the predominantly confirmation phase (see fig 1). This section provides detailed phases, processes and procedures on how the study data was collected. The data collection processes discussed in this section implies a linear process, but the method actually involved a complex process with several processes such as data collection and analysis in operation at once.

*Fig 1: Data collection phases*



### **3.6.1: Predominantly explorative phase**

In keeping with grounded theory approach (Glaser and Strauss, 1967, Strauss and Corbin, 1990), during earlier interviews, the researcher used predominantly explorative questions to collect the initial data from participants. In this predominantly explorative phase, the researcher used open ended questions to allowed participants to talk about their experiences from their perspectives. For example, some of such open ended questions used include: *what do you consider to be the main cultural issues that need to be discussed within the curriculum; could you describe what the experience was like for you when issues of cultural competence were discussed in class, etc.* In the predominantly explorative phase, the collected data were mainly analysed purely inductively (Glaser and Strauss, 1967) and the emerging analytic themes or ideas were targeted at exploring more of the participants' incidents, ideas, events and concerns. The aim was to build a rich contextual picture of the activities within the undergraduate nurse training of mental health nurses when issues of cultural competence were addressed within the curriculum.

### **3.6.2: Explorative and confirmation phase**

As further data were subsequently collected, analysed and some of the themes (repeated ideas) began to emerge, the researcher used a combination of exploration and confirmation data collection techniques such as asking exploring questions followed by confirmation questions to participants, as well as exploring emergent new ideas. For example, some of such questions asked include; *could you describe some of the events that were thought to bring racial tensions in class? Why do you consider such statements to be unacceptable etc.* The explorative and confirmation phase was the starting point of the discarding the data that was not related to the aims of the study or to addressing the research question. At this stage, some of emerging early themes (ideas) and concepts were taken back to the participants for confirmation, at the same time maintaining the explorative stance of the study. Examples of such questions include: *What might be your perspective if students said that they did not feel this kind of teaching necessary? Would it be helpful to have guidelines on what should be taught on cultural nursing care?*

### **3.6.3: Predominantly confirmation phase**

The third and final phase of data collection in this study was the predominantly confirmation phase. Consistent with the procedures of constant comparative analysis (Strauss and Corbin 1990; Glaser and Strauss 1967), in the predominantly confirmation phase, the questions asked by the researcher became more focused as the analysis continued and the findings emerged. The researcher used predominantly confirmation techniques to confirm the ideas from different participants from the same groups or different groups. For example, the confirmation questions asked include; *could you please identify and discuss more on those cultural competence programmes that you feel have been incorporated in other modules... and which modules in particular?* This process continued until theoretical saturation was reached, which means that no new data were found that added to the analysis (Strauss and Glaser, 1967; Glaser 1978; Coyne, 1997; Strauss and Corbin, 2008). In this study, when theoretical saturation was reached, the data collection and analysis ended because interviewing further participants yielded only repeated information and nothing new.

### **3.6.4: Data collection phases summary**

Although the researcher presented the data collection phases as a series of sequential tasks, this was only for the purpose of exposition. Like everything else in qualitative research, the data collection phases were nonlinear. The procedure was a back and forth process, in which the collected data for the later tasks lead the researcher to go back and collect further data for exploring, confirming or both. In all the data collection phases, the sample sizes were determined on the basis of theoretical saturation (the point in data collection when new data no longer bring additional insights to the research questions) (Glaser and Strauss 1967, Glaser 1978; Strauss and Corbin, 1990). By using theoretical sampling in this study meant that all the successive data collection apart from the very first collected data, sampling was not pre-determined before the collection began, but were directed by the emerging themes from the previous data analysis. The reason behind was because as the concepts were identified and the new themes started to develop, further data for confirmation was needed to be incorporated in order to strengthen the initial

findings. The theoretical sampling was also used midway or just before theoretical saturation was reached as a means to confirm, elaborate, and refine themes and to confirm the rigor and trustworthiness of themes. To do this, the researcher returned back to particular participants to collect further data that were used to clarify certain emerging ideas or constructs before the saturation was concluded.

### 3.7: Interviews with senior lecturers

Following informed consent and a brief study introduction, the researcher began each interview session with each of the nine senior lecturers from the university settings that participated in the study. Each of the senior lecturer participants was reminded of his or her right to withdraw from the interview at any time, although no participant chose to do so. The nurse educators were interviewed individually as it was felt that diversity in seniority and experience may have limited the ability of some senior lecturer participants to provide open and honest responses in group setting. Individual interviews were particularly suited for this group because the focus of interviews were to encompass the “*how, why*”...as well as the traditional “*what*” individual participants views as informed by the aims of the study and the research question. The interviews were guided by the interview guide and were typically forty five minutes to one and half hours duration. This was due to the inductive nature of the the methodology used which forced the researcher to deviate from the initially planned time in the pilot and also the information initially given to participants. In subsequent interviews, participants were warned before the interviews that the planned time and what actually could end up happening in actual interviews. The interviews were audio-recorded with participants consent and were later transcribed verbatim.

The interviews with senior lecturer participants utilised different formats and techniques such as being explorative, narrative, reflective, and confirmative (Glaser and Strauss 1967; Strauss and Corbin, 1990; Chiovitti and Piran, 2003), in order to develop a comprehensive understanding of how cultural competence could be addressed within the curriculum. The very first few interviews with senior lecturer participants involved open questions and were purely exploratory as discussed in section 3.6.1 of this study. For example, those interviews began with introductory questions, where participants were asked non-controversial questions about their career background to put them at ease in the interview settings. For instance, the initial questions included: *Tell me about your work at this university. What are your main responsibilities? When did you become part of the university staff? What is important for you about your work? Talk with me about your teaching/assessing/mentoring. How did you come to teach/assess?* These sorts of questions allowed senior lecturer participants to share what was significant for them in terms of their teaching or assessing roles.



As the interviews progressed, senior lecturer participants were asked questions focused at soliciting their personal experiences, views, ideologies about their understanding, the design and delivery of cultural competence within the curriculum. Examples of such questions include: *What do you consider to be the main issues that nurse educators should be focussing on when designing the courses to prepare students for work with diverse population? What main topics do you think that cultural nursing care teaching should encompass at pre-registration training? What kind of learning outcomes would you like to see established for cultural nursing care?*

The questions in this category also probed on the way nurse educators assess the students as a way of achieving the cultural components knowledge and skills within the curriculum. For example, the researcher included probes such as “*please explain what you meant by...*” as a way of eliciting more detailed information from the participants and as a way of ensuring that particular topics were covered. Such techniques are highly recommended by many researchers (Broom, 2005; Polit and Beck, 2004). The interview questions were also targeted at soliciting information on the sources of guidance the educators had in terms of planning and delivering cultural competent curriculum, as well as any relevant models they use. Examples of such questions include: *Would it be helpful to have guidelines on what should be taught on cultural nursing care? Are you aware of any guidelines on how cultural nursing care could be addressed within the curriculum? Please say them (if any). What are the sources of such guidelines (if any)? How do you prefer such guidelines to be constructed?*

Subsequent interviews with senior lecturer participants were exploratory and confirmatory as they were used to explore and verify the meanings shared from the previous discussions with the same or different participants, from the same or different interviews. For instance, the senior lecturer participants were asked to discuss any factors that facilitated or hindered their ability to effectively deliver the cultural competence programmes within the curriculum. For example, the researcher included questions such as: *What are some of the barriers that are likely to be encountered by educators when teaching cultural nursing care within the curricula? How do you prefer those barriers to be overcome or addressed?*

As the data collection and analysis from different nurse educators progressed, more structured, theoretically derived questions for senior lecturers were developed. Examples of these questions included: *What might be your perspective if students said that they did not feel this kind of teaching necessary? What recommendations and improvements do you have for future that could*

*be used when teaching cultural nursing care? How do you prefer students to be assessed as evidence of achievement of learning outcomes of cultural nursing care?* These later questions focused on reflecting and confirming issues that emerged across previous interviews with the same and or different study participants.

The incoming information from participants also sharpened the focus of the interview guides by adding interview questions. For example, as participants offered information, questions on the interview guides were added to ensure that descriptions of what constitute cultural competence training within the curriculum were grounded in participants' meanings. For example, senior lecturer participants introduced constructs such as '*curriculum already over-stretched, cultural competence embedded in other modules such as sociology of health and illness, we give students case scenarios about the cultures different from their own*' and so on. These codes were added to the interview guide as questions. For example, the code of '*cultural competence embedded in other modules such as sociology of health and illness*' was added to the interview guide as follows: *What are the situations you encounter in your day-to-day teaching practice that will help me to understand what you mean by the discussion which are focused on culture invites issues of racism?* (See appendix 1).

The final part of the interview with senior lecturer participants concluded with questions requiring the participants to classify their ethnicity, as well as asking them to suggest any topics that they felt might have been left out in the interview discussions. Examples of such questions included: *How would you classify your own ethnicity? Is there anything else that you would like to add – either more about what we have covered or anything you feel I may have left out? What recommendations and improvements do you have for future that could be used when teaching cultural nursing care?*

Following the one to one interviews sessions with the educators, the researcher summarised the main points from the interview sessions as a way of soliciting feedback from the participants to ensure that the meaning of what the participants intended was captured. The researcher asked educator participants to add what could have been possibly omitted from the interviews. Examples of such questions include: *Is there anything else that you would like to add – either more about what we have covered or anything you feel I may have left out? What recommendations and improvements do you have for future that could be used when teaching cultural nursing care?* The interviews were transcribed as close to collection as possible to ensure clarity of the participants' voice.

### **3.7.1: Collecting curricula materials from senior lecturers**

In addition to the interviews, the researcher also collected the relevant curriculum documentation materials used by senior lecturers to teach students on issues related to cultural competence practice as one of the secondary sources of data. These were used for triangulation purposes. In social sciences, triangulation is often defined as the mixing of data or methods to get diverse viewpoints upon things or topic being studied (Denzin and Lincoln, 2005).

Senior lecturers were asked to supply some of their curriculum documents they use when addressing issues of cultural competence within their curriculum immediately after the interview process. Curriculum documentation materials collected included: vision statements, lesson plans, handouts syllabuses, module guides and other relevant cultural competence training documents. The curriculum documentation data were coded separately from the interview data and provided a means to confirm information from the study participants (educators and student nurses). Triangulation was more important during the data analysis especially when contrasting the data from interviews and documentary curriculum materials. The researcher of this study analysed the content of several curricula documents used in nursing schools that participated in the study to determine whether they cover common core constructs and competencies as described by the study participants during the interviews. The triangulating of data sources was also useful during the analysis as it also helped the researcher to reframe some of the interview questions. For example, when student were asked about their feeling when issues of cultural competence were addressed in classroom settings, some nursing student participants said they have never had any module or teaching about cultural competence. When the researcher looked at the module guide given by the same institute, he found out that the actually had covered a diversity module and that they were using different terminologies. As a result of this triangulation the researcher reframed some of the questions. In addition, the triangulation used in the study did not only validate interview data, but it also helped the researcher to develop a deeper and wider understanding of the phenomena under study.

### 3.8: Interviews with clinical mentors

Four face-to-face individual interviews were conducted with two clinical sign-off mentors and two student clinical mentors from the student clinical practice settings where student nurses do their clinical placements during their work hours. Interviews lasted between one hour and one and half hours duration and were audio recorded with participant consent.

Initially, the interview questions with these study participants were open-ended, broad in scope and purely exploratory (Glaser and Strauss 1967; Strauss and Corbin, 1990; Chiovitti and Piran, 2003). For example, the initial questions which were on the initial interview guide of both the clinical educator participants contained some general questions such as: *Talk with me about your mentoring/assessing role. What do you do on a day-to-day basis in your mentoring/assessing roles with nursing students in this setting? How do you feel about what you do in mentoring/assessing on a day-to-day basis? Please describe an actual experience you have had with nursing students working with patients in the clinical setting that will help me understand what cultural competence means to you* (see appendix 3). These general questions elicited dense and rich descriptions of cultural competence from the perspective of clinical nurse educator participants; and, sharpened the focus of further questions that were incorporated in interview guides for similar and or different participant groups. In the final part of the interview, interview questions were highly confirmative. The study participants were invited to confirm what was said in the previous interviews from the same or different participants.

### 3.9: Individual interviews with student nurses

Following informed consent and a brief study introduction, the researcher began each individual interview session with student nurse participants using the interview guide. These interviews were conducted to ascertain their understanding and the current instructional issues surrounding the teaching and learning of cultural competence within the curriculum. The interviews used some techniques such as being highly explorative, explorative and confirmative and highly confirmative and they were audio recorded with participants' consent and they were later transcribed. The interview discussions lasted until the participants had nothing new to add, usually forty- five minutes.

At the outset, the interview questions were open-ended and broad in scope. For example, the interviews began with introductory questions, where nursing student participants were asked non-controversial questions about their studies to put them at ease in the interview setting. For instance, the initial questions included: *Tell me about your course progress to date? How far are you in your nurse training? When did you start your nurse training? When are you finishing your nurse training? Where do you intend to work when you finish your course?*

As the interviews progressed, participants were asked questions focused at ascertaining their understanding and the current instructional issues surrounding the teaching and learning of cultural competence within the curriculum. Some of the questions asked include: *What methods and materials are currently being used when addressing the nursing care needs of the diverse people with mental health problems within your curriculum? What do you consider to be the key issues that need addressing within the curriculum/program to prepare student nurses for work with diverse population? Coming back to how the nursing care needs of the diverse population were addressed within the curriculum, what do you think about the content?*

As the data collection and analysis progressed, more structured, theoretically derived questions for nursing student participants were developed. Examples of these questions included: *Imagine once again that you were the lecturer on this course; can you think of any other ways of designing the course/program in order to prepare student nurses for work with diverse population? Will you do anything differently?*

In the final part of the interview, interview questions were highly confirmative. The study participants were invited to confirm what was said in the previous interviews from the same or different participants. For example, the issues of discussion that focused on cultural competence were consistently expressed in relation to inviting issues of racism and superiority of identity in classroom environments. This relationship between open codes became subsumed during axial coding into “dissatisfaction of the way issues of culture are addressed in classroom environments”. Following the focus group discussions with student nurses, the researcher summarised the main points from the discussion as a member check to ensure that the meaning of what the participants intended was captured.

### **3.10: Focus group with student nurses**

Another step taken in the data collection methods was to have focus group with the third year mental health student nurses following informed consent and a brief study introduction. One focus group consisted of three students and another one consisted of six students, with a mixture of males and females in each group. A total of nine mental health student nurses participated in the focus groups.

Focus group interviews were used partly as methods in their own right to collect data from the nursing students and partly as a complement to the one to one interviews and as a way of confirming the other data sources. Using the focus groups, the researcher brought together student nurses to discuss the topic of interest guided by the principal research question and the emerged data from previous interviews. The use of focus groups was considered the most appropriate for the student group as this enabled access to a relatively large number of students within a limited time frame. More importantly, focus groups provided the opportunity for discussion and debate amongst students on this topic. The focus group discussions were effective in eliciting data on the cultural norms of groups of students and in generating broad overviews of issues of concern in ways that were less likely to occur in one to one interviews alone. The focus group were conducted with the purpose of collecting data and observing the effect of group interactions.

A topic guide to aid discussion was prepared beforehand and the researcher chaired the group, to ensure that a range of aspects of the topic were explored. The storming techniques were also used to explore the ideal learning situation. The discussions of the focus groups lasted until the participants had nothing new to add, usually between forty- five minutes to one hour and were audio-recorded with participant's permission, then transcribed and analysed.

One of the advantages observed in the focus groups as compared to one to one interviews was that the process was more efficient as student groups were capitalising on the fact that students in the focus groups reacted to what was being said by others, thereby leading to deeper expressions of opinions on issues covered. However, the researcher noted in the second focus group, some group members were a bit shy to express their views in front of the group probably in fear of being academically incorrect or some racial accusations due to the sensitive nature of the topic. In addition, there were situations where there were some dynamics and racial accusation among group

members from different cultural and racial backgrounds that the researcher felt uncomfortable about. To overcome such discomfort, the researcher had a debriefing with his mentors who were more competent in dealing with issues of culture. The data from the focus groups were also used to inform the design and content of the subsequent interview questions.



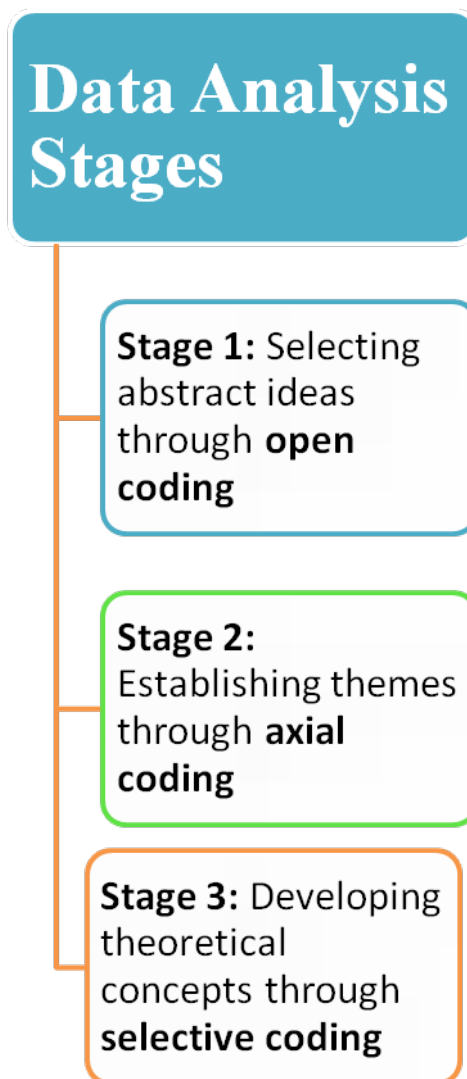
### **3.11: Data analysis overview**

Grounded theory researchers describe data analysis as a process of breaking down, organizing and reassembling data to develop a different understanding of phenomena (Strauss and Corbin, 1990; 1998; Auerbach and Silverstein, 2003). In accord with procedures outlined by Strauss and Corbin (1998) and Auerbach and Silverstein (2003) regarding data analysis for grounded theory research, the following three distinct but interrelated coding stages were implemented in the current study:

- (1) Selecting abstract ideas through open coding,
- (2) Establishing themes through axial coding and
- (3) Developing theoretical constructs or constructs through selective coding (see fig 2 below).

The coding stages listed in fig 2 imply a linear process, but the method actually involved a matrix with several processes in operation at once. The analysis of the data was performed by the single researcher and validity of interpretations was spot checked by the researcher's supervisors during the pre-arranged regular supervision meetings. This section describes and demonstrates how the raw textual data from the participants' interview transcripts were deconstructed, and subsequently reorganised to provide an understanding of how key participants within the undergraduate mental health nursing education prefer issues of cultural competence to be addressed within the curriculum in the form of a conceptual framework. Examples of coding interview data are included in this section to illustrate the process.

*Fig. 2: Data analysis stages*



### 3.11.1: Stage 1: Selecting abstract ideas through open coding

Soon after collecting the interview data from the participants' interviews, the researcher transcribed the audio recorded data verbatim creating a textual database for open coding. In line with the grounded theory principles (Strauss and Corbin, 1990; 1998; Auerbach and Silverstein, 2003), open coding was part of the first level data analysis whereby all the transcribed data from the participants' interviews (textual database) started to be broken down, (conceptualised) analysed line by line, sentence by sentence, paragraph by paragraph in search for key issues or 'codes' to the principal research question and the purpose of the study.

In the open coding process, the researcher read through each of the interview textual data base, contextualising any ideas related to addressing the research question and the purpose of the study. When coding the ideas (and concepts), the researcher looked for any facts, views, information, opinions and incidents that proved to be valuable and relevant to address the research question or the purpose of the study. The researcher then extracted the texts which were related to addressing the research question and pasted them on the created word processor file for that particular interview (see appendix A: Participants Ideas). The texts extracted were the actual "words of the participants" or "excerpts" as from the study's philosophical point of view the researcher was more concerned in reporting the subjective experiences and perspectives of the select group of study participants.

For the purpose of this discussion, an "excerpt" refers to a passage or quotation taken or selected directly without any alteration from textual database of participants' interviews.

The remaining texts from the textual data base from each of the interview transcripts which were not selected due to their irrelevant to addressing the research question and or the aim of the study were either discarded or taken as lonely ideas as discussed in the preceding sections of this study. For example, some of the relevant texts (excerpts) which contained the abstract ideas that were coded were:

*"If they aren't prepared to provide proper care to them, so why invite them in the first place"*  
*[SIFG1].*

*" ..... As an Asian student, every time we have lecturers that involves cultures, I hate it, .....especially when one of the lecturers mentioned that he hopes the discussion would not offend*

*anybody again looking direct into my face as If I was the only person who got offended.....”[S2FG1].*

*“...if you go to Rome, you are expected to do what in Rome the Romans do, but why is it that that when people come to Britain, they expect the British to be experts in those foreign cultures? ... [SN7].*

*If It’s that important they would give us assignment or test to assess us..... So why bother for extra burden that does not look like part of the requirements to achieve the nurse training.....” [SN4].*

*“..... I think as nursing students we have more important modules that are formally assessed to worry about than spending our precious time debating and racially accusing one another ..... just because other people think there cultures are more superior than others.” [SN5].*

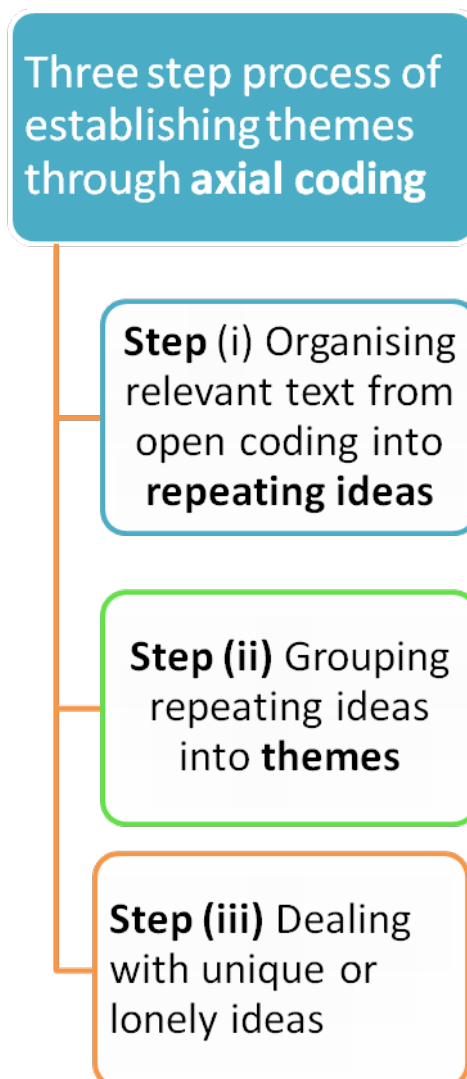
Such initial coding yielded many textual ideas which were later compared with others already discovered from the same or different interviews and regrouped, renamed and modified as will be illustrated in the next coding stage. Please note that this method of coding was done manually by using a word processing program in order for the researcher to be fully immersed into the textual ideas to acquire enormous familiarity with the text to the point of memorisation. This manual coding process using word processor program proved valuable when the researcher was developing his conceptual framework in the final stage of coding.

### **3.11.2: Stage 2: Establishing themes through axial coding**

The second stage of data analysis in this study involved the researcher reassembling and re-grouping abstract fractured ideas (selected in stage 1, see appendix B) from different transcripts into repeating ideas, and the repeating ideas into themes, a process also known as ‘axial coding’ (Straus and Corbin, 1998, p. 124). For the purpose of this study, “themes” were simply groups of repeating or similar ideas indicated by the coded data rather than concrete entities directly described by the participants that link substantial portions of the interviews together. In this stage, the researcher related open coded fractured participants’ ideas to each other via a three step process as suggested by Auerbach and Silverstein (2003) namely: (i) organising relevant text from open coding into repeating ideas, (ii) grouping repeating ideas into themes and (iii) dealing with unique or lonely ideas (see fig 3).

At this stage, the researcher compared coded ideas to other coded ideas from the same and across interviews and determined whether or not they represented the same or different concepts. This was one aspect of constant comparison (Milliken and Schreiber, 2012). The three steps axial coding process is detailed below with examples from the current study.

*Fig 3: Three step process of establishing themes through axial coding*



### 3.11.2.1: (i) Organising relevant text from open coding into repeating ideas

Following the initial analysis (open coding) of a few transcripts, the researcher looked back through the identified extracted participants' ideas in each of the interview transcripts conceptualising them for similarities and differences to establish similar or repeated ideas that emerged within and across the interview transcripts. After selecting a substantial amount of relevant text, the researcher noticed that different participants used the same or similar words and phrases to express the same ideas. The researcher referred these similar or same ideas as "repeating ideas". The researcher then systematically searched the selections of relevant texts (excerpts) for repeating ideas in each of the separate open coded interview transcript data base. The researcher then eventually combined all the repeating ideas into a composite list from all transcript data bases. For example, some of the excerpts of the repeating ideas that were expressed include:

*"If they aren't prepared to provide proper care to them, so why invite them in the first place"* [S1FG1].

*"Some of these people [ethnic minority] it's not their choice to be here, they were forced, circumstances drove them to loose their identity, let's not forget the days of slavery, slavery is over and let's give them the care they deserve....."* [S3FG2].

*"....I don't remember us doing much during our time, however, I have attended a lot of diversity courses in practice....."* [CM 2].

*"..if people can do their maths right, of course they will determine the proportion amount of time to be spent addressing diversity within the curriculum. I am not denying that people's needs should be ignored, but issues of culture have been blown out of proportion ...."* [SL4].

*".... It's clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn't important.."* [SN4].

As an example, the researcher felt that the above excerpts from participants ideas were repeating in the sense that they were expressed by two or more different participants from the same or and across interviews. For example, some excerpt texts were coming from participants from the same focus groups [S1FG1 and S4FG1] and some texts were coming from participants from across different interview groups [S1FG1, SN4, S3FG2, CM2, SL4]. The fact that the repeated ideas were expressed by different status of participants (senior lecturers, student nurses and clinical

sign-off mentors) and from different interviews meant that there were real participants' subjective experiences which were not influenced by the group process. As a result, the researcher grouped those repeating ideas together.

For instance, the excerpts from S1FG1 and S3FG2 were combined together because they both showed that the participants were unhappy about the way the nursing care needs of patients from cultural diverse backgrounds were being addressed within their curriculum. This type of grouping the related texts were done until all the texts were put in their relevant groups. At times the groups were revised and collapsed or rejoined with other groups. In fact such grouping was an ongoing process of which at times the researcher was having the dilemma of determining the point to stop. It must also be noted that this stage was one of the most important stages in the development of the proposed conceptual framework. This is because the final conceptual framework in this current study was supposed to be generated by themes that emerged from the data that captured the essence of meaning drawn from varied situations and contexts during analysis.

### **3.11.2.2: (ii) Grouping repeating ideas into themes**

The second step that was employed in axial coding was to group repeating ideas to establish the themes. From the combined repeating ideas, the researcher began to find something in common about the grouped repeating ideas that expressed an implicitly idea or topic that a group of ideas have in common. The researcher named what each of the groups of repeating ideas had in common a "theme". Using the example in section 3.11.2.1 of texts of the repeating ideas, the "theme" was that the participants in the study were dissatisfied with aspects of how issues of culture were currently being addressed within their curricula. As a result the researcher called this theme: ***"Dissatisfaction with aspects of how issues of culture are currently being addressed within the curricula"***. This theme and many others were named using a short quote that captured the essence of each of the repeating ideas in a dramatic emotional and vivid way as expressed by study participants. Furthermore, in naming the themes, the researcher read around all the repeating ideas in each of the interview transcripts and at times combined quotes or gave some slight paraphrases. The purpose was to try and find some words and phrases that depicted the



participants' emotional feelings in a more vivid way. Sometimes, it was difficult to find those quotes or paraphrases that captured the repeated ideas in a much more vivid way and the researcher ended up giving a description of the theme using a brief statement of the ideas. Further discussions and examples of the established themes have been provided in the findings chapter.

### **3.11.2.3: (iii) Dealing with unique or lonely ideas**

During the process of grouping repeated ideas together, the researcher found that there were some texts (open coded abstract ideas) which did not go together conceptually with any other selection. The researcher referred such texts as “unique or lonely ideas”. Depending on the researcher's assessment of them, some of the unique ideas were either discarded because there were unimportant. Some were included as lonely ideas because they would have been expressed by a single participant. For example, one such unique idea was expressed by one senior lecturer who seemed to prefer the assimilation model of addressing cultural competence by mentioning the following; *.....If people want to base on statistics, then they I think we are doing much more in terms of addressing the care needs of foreigners and other non White British people. Whether you want to say the last census gave the population of the ethnic minority to be 6% or 10%, then I think we are putting more than 10% effort in trying to address the care needs of these ethnic minority people ..... these reports such as the Bennett Inquiry they say what their authors wanted to say ....[SL4].*

Such an idea which was only expressed by one senior lecturer participant was included in the final themes. In both occasions where the unique ideas were rejected or included, the researcher reflected the differences as well as the commonalities. During reporting, the researcher included those lonely or unique ideas by mentioning that ‘only one participant had a particular experience’. The reason of including the unique ideas is because qualitative research is not focussed on quantity but also to demonstrate that individual differences have an important place in the qualitative paradigm.

### 3.11.3: Stage 3: Developing theoretical constructs through selective coding

The third and final stage of the data analysis in this current study involved the organisation and categorising of the emerged themes into theoretical constructs that illuminated the constituents of culturally competent curriculum as a way of formulating the framework to explain the situation and its resolutions. In this stage, the analyses moved from being descriptive to a more abstract level through selective coding process. For example, the themes that were identified in the results chapter were further related and compared to each other by a process termed as constant comparison (Glaser, 1978; Strauss and Corbin, 1998; Ezzy, 2002; Broom, 2005) into more abstract groupings termed here as ‘theoretical constructs’, and also known by other researchers such as Auerbach and Silverstein (2003) as theoretical constructs.

**NB:** For the purpose of this study, ‘a theoretical concept or construct’ is simply a more abstract term or terms that is or are semantically defined by its or their association or usage with other terms that are not directly observable from participants’ excerpts (Auerbach and Silverstein, 2003).

In this process, the researcher continuously shifted perspectives and moves back and forth among participants’ perspectives, other perspectives, and his emerging conceptualizations. This was more like conducting an internal dialogue between and among the perspectives of participants until an understanding became clear to the researcher. From the perspective of symbolic interactionism (Blumer, 1969), thus, the researcher, in taking on the roles of others, engaged in an ‘internal dialectical process’ (Milliken and Schreiber, 2012, p. 688) from which he formulated a framework to explain the situation and its resolution as a solution to the guiding research question. The process involved picking up a starter theme from the themes already emerged from stage 2 of the data analysis section and then relating that theme to other themes in the list. The researcher then moved down the whole list of the themes relating them to the starter theme. Each time the researcher encountered the theme related to the starter theme, he copied into the new created file of the theoretical constructs. In addition, the researcher described and recorded the connection between the encountered themes related to the starter theme. Such descriptions of the connections were used as the clues to the development of the construct. The group of themes that the researcher ended up with defined the theoretical construct that were named after subjecting them and relating them to selected literature review as will be demonstrated later in this section. The

essential idea of identifying starter theme was to develop a single theme (storyline) around which all other themes could be related to as the central driver. The process was repeated until all the themes were related and put in their respective appropriate groups.

As an example of how the theoretical constructs were developed in this study, an illustration has been provided below with the four themes already developed in stage two:

Theme 3: *Discussions centred on issues of culture are perceived to promote stereotypes and prejudiced assumptions about certain cultural groups,*

Theme 4: *Discussions on cultures bring issues of racism, conflict and controversy,*

Theme 5: *Education centred on cultures brings boredom in class as it appears to be irrelevant to the future,*

Theme 6: *Inadequate cultural competence teaching resources and educators' lack of knowledge hinder the development of cultural competence education.*

In developing the theoretical construct “**Dissatisfaction with how aspects of cultural issues are portrayed in current curricula**”, the researcher started with theme 3 as the starter theme. The researcher then read through the list of all the themes with the starter theme in mind. The process is more or less the same as what the researcher did when he was establishing the theme from abstract ideas with the exception that in this case the researcher used the starter theme instead of the research question or aim of the study in mind. Every time the researcher noticed the theme related to the starter theme, he highlighted it and copied it to the starter theme concept file created. In this case, the researcher noticed that Theme 3 was related to Theme 4 in that they both express some dissatisfaction of the ways the cultural competence learning process were addressed within the curriculum and then copied it to the concept file. As the researcher moved down, he noticed that the starter theme 3 and theme 6 were also related in that reported the dissatisfaction caused by educational materials and approaches in the classroom environment which were not welcoming to diverse learners and also copied it in the same file. In addition, the relationship between starter theme 3 and theme 5 was that participants were dissatisfied with learning about other cultures because it brings boredom in class and therefore copied in the same file as well. The same process was conducted to the remaining themes and all the themes were grouped into their respective relating groupings.

### 3.11.3.1: Use of literature review to name the theoretical constructs

In naming the grouped themes into theoretical constructs (constructs), the researcher drew on the selected literature and his general knowledge to find theories or constructs that closely explained the connection and organisation between or among the selected grouped themes. The literature review was performed parallel to the elaboration of the themes into theoretical constructs and later in the development of the proposed conceptual framework. The researcher then named the theoretical construct based on the language of the theory on which he drew his literature from. In this process, the initially developed constructs were organised into very concrete ways by subjecting them to the reviewed literature.

For example, in developing the central theoretical concept “**consciousness of the dynamics and discourse of intercultural education**”, the researcher reviewed the literature which showed that cultural competence education demands one to know his or her own cultural background first before being able to understand other people’s cultural backgrounds [theme12] and that such could only be achieved in a welcoming student learning environment taking into consideration the diversity of learners [Theme 7]. Some study participants felt that issues of cultures are inadequately incorporated into current curricula [theme 1]; while others felt that such issues are incorporated in other modules [theme 2]. Other study participants felt the need to involve cultural competent experts such as community leaders to come and teach cultural competent specific areas whilst others argue that it will make students think that cultures are discrete and are represented by their community leaders [theme 9]. The literature also suggested that the process of cultural competence education is a slow process that needs participants to understand and familiarise with such differing ideological views in order to be able to deal with them effectively. The same literature further states that during the process of cultural competence education, the people’s identities and views are challenged by other people’s ways of doing and thinking and this occurs not always without conflict (Adams et al., 1997; American Academy of Paediatrics Committee on Paediatric Workforce, 1999; Kai et al., 1999; Muntaner, 1999; Trentham et al., 2007).

Therefore, after carefully analysis of the themes and related literature, “**consciousness of the dynamics and discourse of intercultural education**” was considered the bridging central theoretical construct which binds the rest of the constructs together. In naming the theoretical constructs, the researcher strived to use the language carefully, both in how he listened to

participants and how he wrote the theoretical constructs. In other words, the researcher tried to be as clear as possible in translating the data to the reader and participants' stories into theory (Milliken and Schreiber, 2012). Further discussions and examples of the established theoretical constructs will be provided in the discussion chapter.

### **3.13: Rigor and trustworthiness overview**

In any research study, the rigor and trustworthiness of the research findings are important concerns, and as a result, a number of researchers have recommended that all studies adhere to a recognised process for ensuring study rigor and trustworthiness (Lincoln and Guba, 1985; Rubin and Rubin, 1995; Denzin and Lincoln, 2005; Creswell, 2007; 2009). From the onset of the research process the researcher became aware of the importance of providing checks and balances to maintain acceptable standards of the whole research process. This was partly influenced by the repeated advice from the researcher's team of supervisors who repeatedly mentioned that they expected to see some form of rigor and trustworthiness in the whole research processes. In this study, the researcher has produced "a conceptual framework for developing cultural competence in undergraduate nursing education curriculum that is relevant and inclusive to diverse learners" which is rigorous, trustworthiness, useful and relevant to the UK context. In establishing rigor and trustworthiness, the researcher employed the criteria outlined by Lincoln and Guba (1985) which focuses on ensuring study auditability, credibility and conformability. Consequently, in establishing trustworthiness of the study, the researcher used the criteria suggested in Rubin and Rubin (1995) which considers factors such as transparency and communicability, in addition to triangulation criteria from Lincoln and Guba (1985). Therefore, this section demonstrates how issues of rigour and trustworthiness were addressed in this study following the criterion from Lincoln and Guba (1985), as well as Rubin and Rubin (1995).

#### **3.13.1: Auditability and transparency**

In this study, auditability and transparency (Lincoln and Guba, 1985; Rubin and Rubin, 1995) were guaranteed by providing an audit trail of detailed steps of how the researcher arrived to his final interpretation of the data (theoretical constructs). The audit trail was further enhanced by using tables that linked and demonstrated relevant themes and concepts. For example, the researcher showed which repeating abstract ideas built up each of the themes. Additionally, the researcher showed which abstract ideas (excerpts) were used and where those abstract ideas came from (which participants). Such transparent procedure would allow the readers to know exactly what the researcher did in order for them to make their own judgments about the whole process

based on transparent facts. If the methods and the process used are seen as transparent and auditable, this means that the current study is rigorous and trustworthy.

### **3.13.2: Communicability and credibility**

Soliciting feedback from participants also known as ‘member checking’ (Maxwell, 1996) was one of the most important techniques that were employed by the researcher to help improve the communicability and credibility criteria of this study. Since this study involved the single researcher’s interpretation of the research findings, it was decided by the researcher to solicit feedback from participants as a way of using the participants to confirm the accuracy of the interpretation of the findings. Soliciting feedback from participants was carried throughout the interview process, where the researcher constantly checked his understanding of the phenomenon being discussed by the participants utilizing techniques such as asking participants to re-paraphrase summaries and clarify some of the concepts in the discussions. For instance, in terms of fulfilling the communicability criteria, as outlined by Rubin and Rubin (1995), the researcher discussed his finding with the research participants through emailing the established themes to them and sometimes taking the established themes back to the participants to find out whether they did agree with the findings as representing their views and opinions from the interviews conducted. For example, some of the original participants were emailed a summary of the emergent themes, with a transcript of quotes that illustrated those themes. Participants were asked to comment whether they agreed or disagreed with the themes. Some of the participants acknowledged and recognized the themes because the researcher used their actual words as much as possible in establishing the themes.

In terms of ensuring that credibility criteria was fulfilled as outlined by Lincoln and Guba (1985), the interpretation of the data in this study was returned to participants to allow for comments on truthfulness of findings. For example, the researcher emailed the participants and asked them to review the analysis sections and comment on whether the findings adequately represented their views and experiences, as well as checking the accuracy of the facts of the collected data in terms of the developed themes.

Soliciting feedback from participants was also carried at the end of the interview process, where the researcher summarised information and the key points at different points during the interview process and then questioned the participants to determine accuracy of the information. Such an approach of returning data and soliciting feedback from participants at the end of the study was found to be crucial as it provided the opportunity to some participants who previously responded in the study to assess the adequacy of the preliminary findings as well as to comment and confirm particular aspects of the findings. For example, some of the participants affirmed that the summaries reflected their views, opinions, experiences and feelings, while some participants disagreed with some of the findings as not reflecting their views. In circumstances where the participants affirmed the accuracy and completeness of the findings, then the findings were considered by the researcher to have credibility and they were included in the final thesis. Where disagreements were identified during member checking, this was an opportunity for the researcher to correct the perceived interpretation errors and also challenged part of the findings and interpretations that were perceived as wrong. By so doing, more opportunity was given to the participants to provide further information which was also audio-recorded, later transcribed and analysed.

### **3.13.3: Confirmation and triangulation**

The criteria for rigor and trustworthiness in this study also included strict adherence to the method as well as confirmation of the results for accuracy with some cultural competence education experts and research supervisors for academic application. The researcher discussed the findings with other research students, subject experts and also researcher's supervisors who agreed with majority of the themes and concepts. Some research students and subject experts also recognized some of the concepts because of their experiences in practice and other encounters. Furthermore, current literature was used to confirm this study's emerging themes. Obviously the researcher was not expecting everyone to agree with all his findings, however, as long as a substantial number of different people saw the sense and agreed with the findings, then the study findings can be claimed to have some rigor and can be trusted.

Further, triangulation which is a process of comparing results gathered using different sources or methods to validate or confirm findings (Lincoln and Guba, 1985), was one of the techniques used



to increase the trustworthiness of this study. For instance, the current study included multiple participants (student nurses, senior lecturers, student sign-off mentors and student clinical mentors) and their experiences were compared for similarities and differences in the process of developing a conceptual framework. Additionally, the convergence of information obtained through participant individual interviews, focus group interviews and curriculum documentation materials was analysed to assess the trustworthiness of each information source. Comparison of curriculum documentation materials to the conceptual framework generated through analysis of study participants' interviews provided confirmation to the main constructs proposed in the conceptual framework. For example, the proposed conceptual for developing cultural competence includes constructs that involve the pedagogical methods (case scenarios) that senior lecturers rely on when addressing issues of cultural competence within the curriculum. These findings were validated and confirmed by curriculum documentation materials like lesson plans and case handouts supplied by senior lecturers that noted the use of such methods.

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## **Chapter 4: Findings**

### **4.0: Findings: Overview**

In this chapter, the common themes and messages from the series of interviews, focus groups and observed curriculum documentation conducted as part of this research study are outlined. The aim of the study was to develop a conceptual framework for developing cultural competence from the perspective of key participants involved in the undergraduate mental health nursing education within the UK context, in the West Midlands Strategic Health Authority Region. Those respondents largely represent third year mental health student nurses and senior lecturers in mental health nursing training. It was particularly difficult to engage clinical nurse educators such as clinical mentors and clinical sign off mentors in the research, perhaps not surprisingly given their clinical workload and their mentoring and student assessing roles.

From the process detailed in the methods chapter under the data analysis section, thirteen main themes emerged. This chapter begins by setting out the emerging themes and their repeating ideas (text driven concepts) that emerged from the analysis of the data. For the purpose of this study, a “theme” is simply an implicitly idea or topic that a group of ideas have in common. In other words, a theme could also be referred to as topic or statement representing a group of repeating ideas from different participant interviews. Appendix 12 illustrates the process in which the repeating ideas logically cluster into themes. The readers are again reminded here that the repeating ideas or text driven concepts represented parts of the participants’ excerpts as already demonstrated in the data analysis section of the methodology. The themes discussed in this chapter are seen as key to understanding the implementation of cultural competence curricula context as it evolves, and could be helpful to the educators for determining possible support for ongoing designing and implementation of cultural competence curricula. Although each theme is presented separately, in fact they overlap and interact with one another. The themes are presented in this chapter as subsection headings, and the repeating ideas are in quotes to illustrate the points made. The readers are reminded that these findings may be a reflection of the limitations of the sample size and do not imply that other themes not discussed here are not important topics to be considered in the curriculum.

Following researchers such as Richie et al (1997), the findings are discussed using particular terms to indicate the frequency of participants who presented the same or similar ideas (repeating ideas) as per Table 1. The phrases *the majority of*, *many* and *most* are used in this study to discuss ideas expressed by at least over half of the sub group of participants as indicated earlier by Table 1. The terms *some*, *several* and *a number of* are used to show that over one third but less than two thirds of the named group of participants supported the idea. *A few* or *less* are used to indicate ideas or concepts expressed by less than a third of the named group of participants. Each of the emerged themes is detailed below with a selection of representative quotes with designation of their origin. For example, the key of the abbreviations used is given at the front of this thesis. The numerical number designates which interview, focus group or participant the quote was taken from.

#### **4.1: Theme 1: Issues of culture are inadequately incorporated in curricula**

Based upon interviews with study participants, **issues of culture are inadequately or marginally incorporated in curricula** due to a number of challenges they mentioned. For instance, several senior lecturer participants in this study felt that cultural competence education concepts could be lacking due to a number of factors. For example, one of the senior lecturer participants gave this comment to illustrate the point:

*“Most of the research literature available about culture seems to be from other countries such as America Canada, Australia and New Zealand and you would find its applicability a bit vague due to differing cultural histories across continents.” [SL2]*

Other senior lecturer participants frequently described the content of information on culture in textbook as inadequate and superficial to assist them in their teaching of cultural competence based modules. The following are some of the comments made to illustrate the claim:

*“Some available text books tend to talk about cultures in general without any clear guidance in relation to mental health nursing” [SL1]*

*“We do have some text books stuffed in or libraries but many of them are superficial and lack that detail” [SL3]*

As a result, some of the senior lecturer participants were hesitant to rely on such readily available text books and materials on cultural competence because they regarded them as biased as illustrated by the comments below.

*“Some available text books tend to talk about cultures in general without any clear guidance in relation to mental health nursing” [SL1]*

*“Most books are biased on certain cultures and relying on them will be a myth considering acculturation” [SL4]*

Other senior lecturer participants in the study felt that issues of culture could be left out in the curriculum due to the individual senior lecturer's personal comfort with teaching about cultural issues. Their comments below support such views:

*"It depends with each individual lecturer's comfort in teaching certain cultural topics" [SL5]*

*"We are all supposed to include it in most of the topics we deliver as they tend to involve culture, however, I can not say for individual lecturers" [SL6]*

In addition, several senior lecturer participants reported that their institutions were less helpful in terms of supporting them to effectively teach sensitive cultural issues topics within the curricula as the comments below illustrates.

*"To effectively teach cultural diversity, I think lecturers also need strong institutional support and some professional development in that particular area of which I believe at present it's not that enough" [SL7]*

*"I personally feel that as senior lecturers we are ill equipped to teach cultural sensitive topics and issues related to anti discriminatory practice in mental health" [SL9]*

*"We rarely have professional development into diversity training,..... to be more precise here at [Name of University] we attend three hour diversity training once a year as part of the mandatory training" [SL1]*

Furthermore, some senior lecturer participants in the study felt that issues of culture in the curriculum are left out due to their prior practice experience while others felt that it was due to the ethnic composition of minority students in their classes. The comments below illustrate such assertions.

*"My last nursing practice job was in the predominantly white British community practice for the last nine years and I think it could be very difficult for me to go into depth teaching students about culture and diversity...." [SL2]*

*“Depending with the student group make up, some topics are not worth pursuing if they tend to bring such tensions you have mentioned to me.....I can remember a couple of times when I had to technically change the discussion when I noticed some discomfort in certain students” [SL8]*

Further interviews with several senior lecturer participants also identified a lack of knowledge and support to teach issues of culture as their most problematic teaching concern. The following are the comments to illustrate the point.

*“Sometimes the lecturers might have the interest to research more about cultural issues they would want to teach, but sometimes it’s hindered by the lack of readily available teaching resources within the university....” [SL8]*

*“....I don’t remember us doing much during our time, however, I have attended a lot of diversity courses in practice.....” [CM 2]*

*“I’m personally not an expert in cultural diversity; however they are my colleagues who are more competent to teach diversity than I am” [SL1]*

*“Of course as educators we supposed to do some research about the topic ourselves..... if the topic is a requirement..... it’s not simply enough to say we’re not taught in our training..... however, we can only teach what we are confident in” [SL3]*

Some senior lecturers in this study also reported that they had not been trained in their own teaching preparation to deliver multicultural content and, as a result, did not feel confident and competent to teach it in their courses as illustrated by the comments below.

*“I personally feel that as senior lecturers we are ill equipped to teach cultural sensitive topics and issues related to anti discriminatory practice in mental health” [SL9]*

*“My last nursing practice job was in the predominantly white British community practice for the last nine years and I think it could be very difficult for me to go into depth teaching students about culture and diversity.....” [SL2]*

As a result, some senior lecturer participants felt that if there were readily available guidelines on what to teach in the curriculum it was going to be helpful as a number of them reported that they

were not sure whether any such guidelines are available. Below are some of their comments to illustrate this claim:

*“Yes, there is a possibility that it [cultural competence] could be left out if there are no guidelines to assist educators when designing the nursing modules” [SL6]*

*“Not sure of any guidelines” [SL5]*

*“It would be helpful if we had some sort of guidelines on what to include in the curricula” [SL8]*

Some student nurse participants believed that the nurse training they received prepared them well to provide nursing care to diverse cultural groups. However, some had concerns suggesting that there were only few lessons that were dedicated to the care needs of some Black and ethnic minority groups as reported by one of the student nurse participant below.

*“.... Because of the few lessons we had during our second year and a few lessons conducted by external speakers on diversity, I think I have at least grasped something. ....I feel much more confident now to nurse people who’s cultural backgrounds are different from mine.....”[SN3]*

Another student nurse participant felt that the few lessons that they had were useful but could have helped a lot if more teaching on cultural competence were attempted in the curricula. He put it this way:

*“..... Although it was challenging during the process of learning about cultural diversity due to tensions in class, overall I found those few lessons beneficiary although not enough to say I am well prepared to be released and effectively work with cultural diverse patients.....” [SN1]*

Some students who participated in focus groups also asserted that topics on cultural issues were inadequately or marginally incorporated just to cover some legal or professional requirements as suggested by their comments below:

*“ ..... to me I would say issues of culture were marginally incorporated in the curriculum just to cover the legal and professional requirements .....” [SN7]*



*“.... To say we didn’t cover issues of culture and diversity, I’ll be lying, and again to say we really covered such issues, I’ll be vague. The truth is that lessons on culture and diversity were introduced, then run over in a couple of minutes then moved on to the next topics.....” [S1FG2]*

*“..... Yes X is right, our lecturer just whitewashed issues of culture and asked us to research more without telling us whether feedback was needed from us or not.....to me it was like as long as they are covered..... from such an approach it’s difficult for me to give a definite answer to say I’m prepared from such lessons we had on cultures because I didn’t do it and nobody asked me why....” [S2FG2]*

In addition, nursing students who claimed to have received cultural competence education were more likely to report having intentions to treat with confidence patients from other cultures.

*“ .....from few of the lessons we had in class and some talking from the externals such as ex-patients and carers, at least I’m a bit confident of the expectations when I go into practice after summer.....” [S3FG2]*

On the other hand, majority of third year mental health nursing students who participated in this study also doubted on the content of cultural issues within their curricula and its possible effect to their knowledge and skills. These students based their arguments on the fact that they had only had few lessons dedicated to cultural competence issues. Some students gave these comments to illustrate the claims made:

*“With only a few lessons centered on cultural nursing, it’s hard to say with certainty that our own training prepared us enough to nurse diverse cultural groups....” [SN1]*

*“Only now in our third year, I can remember having ex- clients and ex- carers coming to talk about their experience of the nursing care they received from the mental health staff and how they preferred to be cared... it could have been more beneficiary if we had more of these training from our first year...” [SN2]*

*“.... Because of the few lessons we had during our second year and a few lessons conducted by external speakers on diversity, I think I have at least grasped something. ....I feel much more confident now to nurse people who’s cultural backgrounds are different from mine.....” [SN3]*

Other student nurse participants in this study felt that there was the same cultural information that was being covered throughout their undergraduate mental health nursing using the same depth. Comments to illustrate such points included:

*“ .... Issues of culture are covered a lot throughout the undergraduate curriculum but not in a meaningful depth to distinguish stages of progression.....” [SN3]*

*“ .... When discussing issues of culture in classroom environment, our lecturers always gave the same or similar examples in each and every lesson” [S3FG2]*

*“Learning the same issues every time throughout the three years becomes boring and is not helpful” [S1FG2]*

Such student comments suggest the need to further elaborate the way issues of cultural competence are addressed within the current curricula. While it is clear that the impact of culture on mental health is complex, there is the perception from the study participants that integrating cultural competence education into the training of nurses is associated with improved patient satisfaction to care. When asked whether participants think culture has any impact on mental health, some senior lecturers gave theses comments:

*“.....although we are including cultural competence in our current curricula, I think as nurse educators we probably need to do more than what we are doing now .....I strongly believe that integrating cross cultural education into the training of nurses may improve nurse patient interactions among the marginalized patients and there is a lot of research to support me.....” [SL3]*

*“As lecturers, I think it’s very wrong for us try to engage ourselves into these political debates where we view cultural diversity narrowly as ethnic customs and immigrant religious beliefs...” [SL8]*

Another senior lecturer responded to the same question using this expression;

*“.....definitely culture has a lot of impact on mental health, for example, in nursing, ..... the NMC requires students to provide choice to the clients.....therefore, students need to know that in*

*order to provide greater choice and satisfaction to patients, they need to be aware of the patient's beliefs, values and desires..... which in most cases are culturally formulated...” [SL6]*

One of the student nurses also raised the same sentiments that their curricula is not doing enough and they wanted more of those lessons which the student found to be beneficiary in practice. The student gave this comment:

*“Students and nurses need to know how cultures shape every aspect of the nursing process up to the extent of planning appropriate services for patients during discharge..... This reminds me of one illiterate client who was from Somali origin. As part of the discharge aftercare the nurse suggested that the social worker access funding for the client to attend local Bingos to minimize loneliness. I happen to know the local Bingo club in question which was used by predominantly White elderly people....” [SN6]*

Some student nurse participants also felt that cultural diversity issues are only marginally addressed in the curricula for the sake of being compensatory to the diverse ethnic groups of students in classroom environments as illustrated by the following comments.

*“.... It's clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn't important. If It's that important they would give us assignment or test to assess us..... so why bother for extra burden that does not look like part of the requirements to achieve the nurse training.....” [SN4]*

*“It's unfair when lectures give summary statements about the cultural beliefs of Africans as if Africa is a single country” [SN2]*

In addition, some findings from the study participants seem to suggest that where issues of cultures were incorporated in the curricula there were marginally incorporated just to meet the enforced minimum regulatory standards as illustrated by the following comments.

*“Some of our lecturers seemed to pick and choose the topics which they think will be liked by students... if topics that bring tension in class arose, the lecturers will divert to another topic...”. [SN2]*

*“It’s simply a cut on the edge [lessons on cultural nursing care], so long as if it’s covered, some aspects such as providing an interpreter are not fully discussed...” [SN3]*

*“Some lecturers try very hard, of course we don’t expect them to know it all in details, there are so many of them[cultures] and some of those cultures prefer the aspects of their cultures to remain private to them..” [SN6]*

Some learners who participated in this study view the current way the cultural nursing care needs of diverse patients are being addressed within the curriculum as a failure. There is also a perception from some White students who participated in this current study that the system is too lenient to strangers and foreigners and thereby demanding too much from them in terms of learning how to provide appropriate nursing care to foreigners as illustrated by the comment below.

*“...if you go to Rome, you are expected to do what in Rome the Romans do. Why should it be that when people come to Britain, they expect the British to be experts in those foreign cultures? ... isn’t this unfair and an extra burden to our society...” [SN7]*

*“..... after all why should the lecturers waste their time and our time teaching on how to provide excellent nursing care to strangers..... We didn’t come to the university to learn about providing excellent nursing care to foreigners .....” [SN7]*

Such comments from the student nurses in this study possibly suggest that even qualified nurses in practice are possibly not being cultural sensitive enough when planning the cultural appropriate services for diverse clients. Therefore, it could be suggested that when mental health nursing universities do not make the inclusion of issues of culture in the curriculum a priority, the content would rarely appear. A limitation of this study in terms of the above mentioned theme is that the study did not address how lack of pertinent resources, any prior practice experience in teaching diversity content and lack of training in senior lecturers ‘own preparation to deliver cultural competence content in the curricula would affect the students’ level of cultural competence.

## 4.2: Theme 2: Variation of modules by institutes

Examining the curricula content of higher educational institutions offering pre-registration mental health nursing education from the participating universities in this study, the researcher found no course specifically covering cultural competence. However, majority of the participants from the senior lecturers reported the inclusion of issues of cultural competence as part of instructional content which is embedded across different nursing modules over the three year course. This was also evidenced by some of the curriculum documentation materials supplied by senior lecturers to the researcher. However, it appeared that some nurse educators from the clinical side disagreed that issues of cultural competence are adequately addressed across the curriculum.

Starting with the learning milieu, the nursing student participants identified a number of ways in which they had been exposed to issues of cultural competence content within their curricula, primarily outside of the single module. Majority of student nurse participants identified having been exposed to this content in a variety of nursing modules such as Anthropology, Diversity Awareness, Sociology of Health and Illness and so on. As a result, many nursing student participants had very strong feelings about how cultural competence was integrated into the curriculum. The comments below illustrate such claims.

*“ ..... we had lessons in sociology of health and illness where we learnt about inequalities in health in terms of class structure, ethnicity, social class, races and so on.....” [SN4]*

*“It could be a better idea if we can have modules specifically dedicated to cultural diversity like what we have in other modules” [SN3]*

*“If I were a senior lecturer, I would do more in terms of teaching the nursing care needs of diverse patients as at the moment I feel its not enough” [SN4]*

*“Some lecturers try very hard, of course we don’t expect them to know it all in details, there are so many of them[cultures] and some of those cultures prefer the aspects of their cultures to remain private to them..” [SN6]*

One student nurse participant commented that her cultural encounters had been in the clinical placement which had a large client group of patients from different cultural backgrounds and has been a good experience regarding the needs of people from different ethnical backgrounds.

*“ ... my previous clinical placement had patients from different ethnic, racial and cultural backgrounds and I gained a lot of skills and knowledge from them during our interactions....”* [SN5].

The claims were also confirmed by senior lecturers in this study who also gave comments such as: *“..... issues of cultural nursing care needs have been incorporated into other modules such as Sociology of Health and Illness where such issues are explored and discussed.....”* [SL1]

*“..... In one of our Domains of Nursing module, we give student scenarios of patients from different backgrounds to research on their nursing care needs and then they choose the scenario and prepare it for the viva presentations.....”* [SL3]

Some senior lecturer participants also confirmed the comments made by student nurses that they do not have specific modules within their curricula which specifically address cultural competence as illustrated by the comments below.

*“ ... we don't have specific modules within the pre-registration mental health nurse training as issues of cultural nursing care needs have been incorporated into other modules such as Sociology of Health and Illness where such issues are explored and discussed.....”* [SL1]

*“..... you would rarely find any discussions in mental health nursing that doesn't acknowledge the diversity of individuals* [SL3].

One of the senior lecturer participants mentioned that they have got modules on diversity that provides insights into cultural diversity as a stepping stone towards cultural competence as illustrated by the comment below.

*“ ..... I don't believe that there is any one course that teaches students to be cultural competence, however here we have got modules on diversity that provides insights into cultural diversity as a stepping stone towards cultural competence....”* [SL3]

Of those senior lecturer participants who reported inclusion of cultural competence in the curriculum, some reported an informal cultural competence inclusion curriculum as demonstrated below.

*“..... You would rarely find any discussions in mental health nursing that doesn’t acknowledge the diversity of individuals” [SL3].*

In addition, other senior lecturer participants reported the inclusion of a formal curriculum;

*“..... In one of our Domains of Nursing module we give student scenarios of patients from different backgrounds to research on their nursing care needs and then they choose the scenario and prepare it for the viva presentation.....”[SL3]*

Although the senior lecturers in this study reported that they are embedding cultural competence education within the curricula, however, some student nurse participants also reported that they were not learning as much on the needs of diverse cultural groups as the senior lecturers reported they were teaching. The comments below illustrate the claim.

*“Some of our lecturers seemed to pick and choose the topics which they think will be liked by students... if topics that bring tension in class arose, the lecturers will divert to another topic...”. [SN2]*

*“It’s simply a cut on the edge [lessons on cultural nursing care], so long as if it’s covered, some aspects such as providing an interpreter are not fully discussed...” [SN3]*

*“Some lecturers try very hard, of course we don’t expect them to know it all in details, there are so many of them[cultures] and some of those cultures prefer the aspects of their cultures to remain private to them...”[SN6]*

Surprisingly, not all the nurse educator participants felt that issues of cultural competence were adequately incorporated in the curriculum. For example, nurse educators from the clinical practice where student nurses are supervised and assessed for their clinical skills competence, one of the student sign-off clinical mentors in this current study felt that there was no cultural competence inclusive curriculum at all. The comments below illustrate the point.

*“.....the senior lecturers at the universities need to incorporate within their core modules issues of culture and mental health nursing. They also need to teach the nursing students about culture and its impact on them and the communities they will serve. For instance, if the communities they will serve are mainly composed of Moslems, at least they need to teach basic Moslem mental health nursing care needs...” [CSM1]*

*“.... there is evidence from speaking to some of my students that at least they were taught about providing cultural sensitive nursing care, however, there is also a suggestion that some students were not exposed to such teaching at all ...”[CSM1]*

When the researcher asked specifically what the students should be taught, the clinical sign-off mentor said:

*“ .... There are no specificities student should be taught about cultures; however, if they can be taught about the common cultural expectations from different cultural groups, I think this will be enough. There is evidence from speaking to some of my students that at least they were taught about providing cultural sensitive nursing care, however, there is also a suggestion that some students were not exposed to such teaching at all. Probably the multicultural teaching is done; however, I don't think it's done across the board. All students need to be exposed to it. During my nurse training, I don't remember receiving such training at the University....” [CSM1]*

Some study participants expressed the need to do more in incorporating cultural competence into the curriculum. Below are some of their comments that expressed the need.

*“ .... There are no specificities student should be taught about cultures; however, if they can be taught about the common cultural expectations from different cultural groups, I think this will be enough.....”. [CSM1].*

*“In my opinion, I think that integrating and incorporating the concepts of cross cultural nursing care into other modules already present during our teaching may be an effective way of highlighting the importance of cross cultural nursing care considerations not just as an add one extra burden but as an essential component of the holistic patient care.....”[SN1]*



*“ .....There is evidence from speaking to some of my students that at least they were taught about providing cultural sensitive nursing care, however, there is also a suggestion that some students were not exposed to such teaching at all. Probably the multicultural teaching is done; however, I don't think it's done across the board. All students need to be exposed to it. During my nurse training, I don't remember receiving such training at the University....” [CSM1]*

Specifically, student nurse participants felt that more needs to be done in terms of addressing cultural competence within the curricula. Below are some of the students' comments to illustrate such a need.

*“It could be a better idea if we can have modules specifically dedicated to cultural diversity like what we have in other modules” [SN3]*

*“If I were a senior lecturer, I would do more in terms of teaching the nursing care needs of diverse patients as at the moment I feel it's not enough” [SN4]*

Even one of the senior lecturer participant also technically agreed that the current curricula need to be strengthened in terms of addressing cultural competence as illustrated by the comment below:

*“..... whilst I don't deny the possibility that the current nursing curriculum might need to be strengthened in terms of incorporating the cultural diversity teaching, however, at the same time I don't agree on the one size fits all approach”. [SL7]*

One of the senior lecturers in the study strongly disagreed with the fact that the curricula does not address cultural competence, however, the lecturer appreciated that the weaknesses of the current curriculum could be linked to its failure to have formal assessment methods of students as evidence of achievement of cultural knowledge and awareness. The senior lecturer's comment below illustrates the claim:

*“I personally disagree with those who say the curricula doesn't address the care needs of diverse patients, the truth is that there is a lot within the curriculum about non discrimination practice from the national Service Framework of Mental Health to the NMC code practice... what I*

*foresee as the only weakness is that currently they're very few ways of formally assessing student competence and as a result, some student don't take it serious" [SL4]*

Although some of the responding senior lecturers in this study think that multicultural content is being included as part of the mental health nursing curriculum, however, they felt that a lot needs to be done, as illustrated by the comment below.

*".....although we are including cultural competence in our current curricula, I think as nurse educators we probably need to do more than what we are doing now ....." [SL3]*

Moreover, it was evident from the provided curriculum documentation in the study that those higher educational institutions which participated in the study included in their curricula such courses covering cultural nursing care embedded in other modules such as Sociological Perspective of Health and Illness, Inclusive Practice, Domains of Nursing and so on. However, such incorporation or embedment of cultural awareness programs into other modules appears not to be uniform across all the universities which participated in the study. From the interviews with senior lecturers in this study, the common belief of the senior lecturers was that subjects related to intercultural nursing competence have been integrated to other courses or modules within the three year nurse curricula. As a result, one of the themes that emerged from the discussion of both participants in the study is that issues of cultural competence are incorporated in other modules although consistence and quality of training might vary from institute to institute. As a result, the theme **of variation of modules by institutes** was drawn to reflect the concern. Such a theme suggest that although study participants especially senior lecturers mentioned that cultural competence programmes have been incorporated in other modules, however, if consistence varies from institute to institute, this means that the impact of the inclusion is lost. In the light of the findings of this theme, it may be suggested that nursing educators need to intensify their efforts by having a robust system of incorporating or promoting cultural awareness programs into existing curricula so that all students are exposed to it. However, it is difficult to generalize from these findings given their sample sizes and design limitations.

#### **4.3: Theme 3: Cultural discussions invite stereotypes, prejudice, discriminations and religious intolerance**

One of the questions that was raised by the researcher to participating student nurses both in focus groups and one to one interviews was whether the students felt that the nurse education they received so far prepared them to work with diverse clients when they qualify.

Differing opinions and views emerged from students' responses. Some third year student nurses believe that the education they received had prepared them well to treat patients from diverse cultural backgrounds different from their own. Other students expressed the opinion that although elements of cultural competence were attempted to be addressed within their nurse training, there were like "*run-overs, white wash and run on the edge*", implying that it was not properly or intensively done. Some students claimed to have received no cultural competence training at all, although when further interviewed by the researcher, they ended up contradicting themselves. The overall significant premise that resulted from participants repeated ideas is that discussions centred on issues of culture are perceived to promote stereotypes and prejudiced assumptions about certain cultural groups. Therefore emerged theme was that **cultural discussions invite stereotypes, prejudice, discriminations and religious intolerance.**

For example, the nursing student participants in this study perceived that the discussions on cultures promote broad stereotypes and prejudice assumptions about certain cultural groups. For instance, majority of student nurse participants clearly mentioned their dissatisfaction with the ways in which issues of culture are addressed in classroom environments, possibly in terms of bringing racial tensions as such issues were inadequately being addressed or being compensatory to the diverse ethnic groups. The following are some of the comments from students that show their dissatisfactions:

*"..... We didn't come to the university to learn about providing excellent nursing care to foreigners ....."* [SN7]

*“I was upset to hear our lecturer repeatedly saying ‘White indigenous population’ as if they’re no black indigenous populations” [SN5]*

*“It’s unfair when lecturers give summary statements about the cultural beliefs of Africans as if Africa is a single country” [SN2]*

*“It gets deep into my nerves if lecturers time and again refer to Asians and Moslems when they give examples of cultures as if they’re the only cultures on earth” [SN3]*

*“.... It’s clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn’t important. If It’s that important they would give us assignment or test to assess us..... so why bother for extra burden that does not look like part of the requirements to achieve the nurse training.....” [SN4]*

For example, the lack formal ways of assessing learners was viewed by some student nurse participants in this study as a less important module and content to worry about as compared to other taught modules and content. This was because from all the universities visited by the researcher during data collection, there was no single university where there was a formal way of assessing cultural competence of students. This was also evidenced by the observed curriculum documentation materials supplied by senior lecturers to the researcher and also as confirmed by the study participants’ interview comments. Such views of “*why bother*” and “*having more important things to worry*” than studying cross cultural issues may suggest that possibly cross cultural issues might need to be formally assessed if students are to take it serious knowing that if they do not pass the module, they will not be able to complete their nurse training.

However, none of the senior lecturers volunteered to mention that the discussion of cultures bring issues of conflict and controversy without being asked. However, when they were directly asked by the researcher, they indicated that *once and again such issues of racism, superiority of identity do occur [SL9]*. Perhaps the reasons they did not voluntarily give that information without being asked is because they were uncomfortable to discussing these issues. For example, by admitting that these issues exist could be seen as challenging their pedagogical methods or perhaps it has to do with their tradition of presenting cultural competence information in classroom as it were free of conflict and controversy.

Majority of student participants as well as a substantial number of senior lecturers indicated that they had seen, witnessed and or experienced conflict and controversy such as racism, discrimination and superiority of identities in classroom environment when issues of culture were discussed. Comments below illustrate the assumptions.

*“..... at one time our lecturer gave an example of an Asian woman who died in a temple fire and some students began questioning why the lady didn't run away gazing at me as if I was the one with her in the temple... '[SN3]*

*“Some of these people [ethnic minority] it's not their choice to be here, they were forced... circumstances drove them to loose their identity, let's not forget the days of slavery, slavery is over and let's give them the care they deserve.....” [S3FG2]*

*“ .... Before these patients come to Britain, they were at least supposed to think of what could be the consequences when they become ill. Obviously we're not expected to know their single cultural norms in order to be good nurses. People who want to come to England need to know that they are going to England where English people speak English and nurses are not expected to learn their vernacular languages just for the case of trying to nurse them. .... in my opinion, I think issues of language barriers should not be a burden for the nurses and nursing students, but for the patients' families... that is if they wish their own relative to be treated by British Nurses ....” [S3FG1]*

In one of the focus groups, one student nurse mentioned a more or less a similar statement mentioned by the one student in one to one interviews saying:

*“.....we didn't come here [to the university] to spent majority of our time learning about providing excellent nursing care to foreigners only ..... if we spent such a substantial amount of time learning about their needs, how much time are we supposed to spend learning about the indigenous White British people who are the majority? .....” [S6FG2]*

In another one to one interview the student had mentioned that;

*“...if you go to Rome, you are expected to do what in Rome the Romans do, but why is it that that when people come to Britain, they expect the British to be experts in those foreign cultures? ...” [SN7]*

When the researcher asked what the participant thought about the statement which said when you go to Rome, do what in Rome the Romans do, one student gave this comment:

*“it’s pathetic to hear that some people still feel that certain members of the British society don’t belong to the British society and they have to do what in Britain the British do [responding to ‘what the Romans do’] XXX needs to know that even the Caribbean is not their home, they were just dumped there..... remember they came to the plantations packed like bundles of wood in a basket..... Otherwise their mental distress is caused by their disturbed minds about their forgotten identity and roots ..... so we need to give them a thousand percent care” [S4FG2]*

Another student pointed out to the discomfort witnessed to senior lecturers during delivery of cultural diversity lessons.

*“....even some of our lecturers when they teach about diversity, you can tell that they aren’t comfortable with some discussions [SN7]*

Some of the above comments possible suggest that the dissatisfaction of students when issues of cultural competence are addressed may be contributed by the senior lecturers’ statements which seemed to lack cultural sensitivity when discussing cultural issues. The students’ comments below suggest such claims.

*“I think that our lecturers are actually promoting prejudice by asking us to do case studies of especially the Asian and Afro-Caribbean cultures and to come and present them in class discussion.....” [SN6]*

*“ .....the assumptions they teach us about certain cultural groups is not helpful at all....” [SN1]*

Overall, a number of participants from the students’ side felt dissatisfied by the way issues of culture are currently being addressed within their curriculum. However, among those students who reported that there were satisfied with the cultural issues content of their curriculum, there was a strong association their preparedness and willingness to provide cultural sensitive care to culturally diverse patients as illustrated in themes 1 and 2 above.

#### **4.4: Theme 4: Discussions on cultures bring issues of racism, conflict and controversy**

A less mentioned but significant theme related to the previous theme 3, was the students' perception that the discussions on cultures bring issues of racism, conflict and controversy in classroom environments as illustrated by the comments below.

*“ ..... As an Asian student, every time we have lecturers that involves cultures, I hate it, .....especially when one of the lecturers mentioned that he hopes the discussion would not offend anybody again looking direct into my face as if I was the only person who got offended.....”[s2FG1]*

*“ .... The minute I mentioned that some cultural norms that nurses are expected to respect seem to be too primitive..... , some students in class started to Bu u u u me before I finished what I wanted to say.....[SN1]*

Another nursing student participant in a focus group expressed the controversy in a polite way as expressed by her comment below.

*“... those clients from different cultural groups who came to give the talks to students made us more aware of their diverse expectations and that each is different and there is no need of knowing it all as we will ask them in practice and they will tell us.....” [S2FG1]*

Issues of racism, conflict and controversy among student nurses when issues of cultural competence are discussed in classroom environments may be influenced by the timing and the context in which students are taught the skills of working in a cross-cultural society. According to the evidence from the discussions with the learners, some of those cross cultural skills are usually presented in the first year of the student nurse training at a time when students may not have had sufficient patient contact. The comments below illustrate the point:

*“.... It was during our second week at uni [university] when our Sociology in Health lecturer came in class and he started introducing the sociological aspects of mental health topic. The moment he mentioned that some cultures tolerate mental health differently; many students looked at me as if I was the culture being referred to .... And I felt naked.....” [S1FG1]*

Such comments and findings possibly suggest that the students may not recognize the value of learning about cultures before they go to their first clinical placements, or may have had little opportunity to see the importance of those skills in practice. In addition, the students might have little opportunity to learn the theories of cultural competence in class compounded with the belief that it is not formally assessed hence not essential nursing skills and knowledge, as illustrated by this comment.

*“.... It’s clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn’t important.....”* [SN4].

It also appears that even some of the senior lecturers interviewed by the researcher were indirectly denying dedicating more time to teachings centred on addressing cultural competent sensitive topics, possibly fearing such conflict and controversy. For example, when senior lecturers were asked by the researcher about how much time and resources educators think should be dedicated to teachings on issues of diversity, one of the senior lecturers gave this comment:

*“ ..if people can do their maths right, of course they will determine the proportion amount of time to be spent addressing diversity within the curriculum. I am not denying that people’s needs should be ignored, but issues of culture have been blown out of proportion ....”* [SL4]

When the researcher asked for further clarification the senior lecturer participant further went on to mention that:

*“.....If people want to base on statistics, then they I think we are doing much more in terms of addressing the care needs of foreigners and other non White British people. Whether you want to say the last census gave the population of the ethnic minority to be 6% or 10%, then I think we are putting more than 10% effort in trying to address the care needs of these ethnic minority people ..... these reports such as the Bennett Inquiry they say what their authors wanted to say ....”* [SL4]

There is also a general perception from students and senior lecturers that lessons and discussions focussed on diversity invites the issues of racism, superiority of identity, discriminations and



prejudices among students from different ethnic backgrounds. Students who participated in the study expressed fear that any discussion in class centred on culture tend to bring issues of racism.

One student talked about her experiences of being accused as a racist when she tried to express her views on what she thought should be done to address the needs of patients from diverse ethnic backgrounds. Her comment below illustrates the claim.

*“ .... The minute I mentioned that some cultural norms that nurses are expected to respect seem to be too primitive..... , some students in class started to Bu u u u me before I finished what I wanted to say..... Some students openly started accusing me saying do you think your own culture is a more civilised than the rest..... Some started accusing me of making some racial comments when in fact I did not make any racial comments at all..... Our class tutor who is also White just stood up and waited till the arguments were tense between Black students and White student in class. The only thing he said was that the argument was out of proportion and we need to change topics. The atmosphere in class was as if there was a civil war between Black students and White students ....” [SN1]*

Another illustration of how the discussion focused on cultures invites issues of controversy and conflict is from an extract from the interviews below.

*“ ..... when people start discussing about cultural care needs of patients, they tend to look at me as if I am an expert of cultures. Being born by Asian parents does not make me an expert in Asian Culture. I hate it. I hate ..... because people don't stop it. I remember when we were talking about different approaches to death and how nurses should respond..... the moment the tutor asked about what happens with the Sikh..... , all eyes were on me as if I was a Sikh myself..... ”[S2FG1]*

Senior lecturers seemed to fear the unpredictable nature of the discussions and debates focusing on cultures and diversity, but this seemed to be based on lack of skills and expertise to control such discussions and debates. One senior lecturer mentioned that although they try by all means to include issues of cultural diversity within the curriculum, however, sometimes their efforts were hindered by the attitudes of some students which they claimed were sometimes difficult to control and manage. One senior lecturer gave the following comment to illustrate the point:

*“.... We tend to draw up discussion on how the needs of patients from diverse backgrounds could be addressed, however, once in a while you will get students who feel that they are being attacked most of the time because of their cultural affiliations. At times these students would overreact and ended up bringing unsubstantiated accusation to other students. I had one student who openly accused some students of being racists and ended up accusing me of supporting students to bring racial comments. This is an area which is somehow we had to deal with although err er.er....., especially if the students are all mature students. ...” [SL2]*

When the researcher asked senior lecturer participants on how they preferred to deal with cultural diversity discussions where issues of racism and superiority of identity arose in class, one senior lecturer gave this comment.

*“.....I’m not quite sure but I would suggest that any lecturer who wants to introduce sensitive topics on culture and its impact on mental health nursing, I think they should possibly introduce the topic with some epidemiological data and statistics including their proper references so that listeners could see that it’s not the lecturer’s opinion data and there is no stereotyping.... In this way, possibly the students could possibly develop be open minded attitudes”. [SL5]*

Overall, the above findings of the theme suggest that raising awareness and changing attitudes may be more difficult if some students are in denial to the discussion of cultures and diversity, or fear some possible resistance and accusation from fellow students or feel that they are being blamed for social problems that exist. Therefore, such findings seem to suggest that in order for the pre-registration mental health students to value the role of cross cultural nurse education, efforts must be targeted at reducing learner or resistance to cultural competence education and possibly dedicating substantial time in classroom teaching of cultural competence. Furthermore, as reported by study participants, if there are no formal means of assessing learners, teaching cultural competence may be difficulty influenced by the learners' pre-existing attitudes, as well as the context, timing, and content of the cultural competence curriculum. That is why student nurses may have the approach of “*why bother*” for extra burden that does not look like part of the requirements to achieve the nursing qualification. In addition, nursing students may be of the opinion that they *didn’t come to university to learn how to provide excellent nursing care to strangers*.

#### 4.5: Theme 5: Education centred on cultures brings boredom

In expressing their views about how issues of cultural competence are addressed in classroom settings, a considerable number of students' participants in this study reported **that education centred on cultures brings boredom in class** as they consider it to be irrelevant to their future. Majority of student nurse participants further claimed that with such education which focuses on cultural competence issues, they see little or no relevance to their future on what is taught or what they learn. Their reason for such comments could be linked to the way senior lecturers deliver such issues to nursing students as illustrated by the comments below.

*".... When introducing Diversity issues module, our lecturers started by bombarding us with cultural terms that appeared to be coming from Mars and you could tell that most students were confused..." [SN6]*

*" ....I think lecturers need to teach us only about those cultural issues we are most likely to meet in our practice, it pointless to teach us Australian Aborigines..." [SN3]*

In one of the interviews, one senior lecturer had reported that when they teach the Diversity module, they *"start from what the students bring in the classroom environment"* [SL2].

The nursing student participants in the current study however, suggested that cultural competence learning starts from what is considered by their senior lecturers as high-status knowledge, with its overemphasis of the British history, British ways of doing and British values.

*".... I found the lectures to put more than enough emphasis on the British history and the British values as the best standards which other cultures should follow" [SN5].*

*"... our lecturers always claim to say whatever notes they give us is of high class in terms of knowledge about cultures, but most of the time its very confusing and beyond our understanding" [SL7]*

Some students felt that the terminologies used by their senior lecturers when teaching them about cultures are too complicated and difficult to comprehend as justified by the student comment below.

*“..... terms such as transcultural nursing, cultural congruent ethnocentric approaches are not helpful to us especially when introducing the topics” [SL1].*

Other student nurse participants felt that their senior lecturers only choose the topics they feel or are only comfortable to teach and they skip those they feel might bring controversy in class as mentioned by one of the student participants below.

*“they choose topics they want to teach” [SL8]*

The study findings above seem to suggest that there is a profound mismatch between students' cultures and the content of the curriculum centred on cultural competence issues. Some nursing student participants reported that cultural competence learning does not start from what students bring in the classroom environment as proclaimed by some senior lecturers. Therefore, one of the reasons why participants perceive that education centred on cultures brings boredom in class as it appears to be irrelevant to the future.

#### **4.6: Theme 6: Educator's subject expertise and scarce resources impact on cultural competence education**

Another theme that emerged from the interviews with many study participants is that the delivery of cultural competence curriculum is hindered by the inadequate cultural competence teaching resources and senior lecturers' lack of knowledge about cultural issues that need to be addressed within the curriculum and thereby hinder the development of cultural competence education.

From interviews with senior lecturers in this current study, many senior lecturers cited the lack of readily available relevant teaching materials such as books as one of their major concerns that hindered the delivery of cultural competence curriculum. The following comments from senior lecturers illustrate such concerns.

*"Sometimes the lecturers might have the interest to research more about cultural issues they would want to teach, but sometimes it's hindered by the lack of readily available teaching resources within the university....." [SL8]*

*"A substantial bit of what I teach involves a lot of consideration of the cultural needs of diverse people and you would find that our libraries are stuffed with American and Australian stuff which in most cases seemed to be irrelevant here" [SL1]*

Although nurse educators reported that they have no guidelines or educational frameworks that are relevant to their educational system, further discussions seem to suggest that these educators use guidelines from different models unconsciously as suggested by the following comments.

*"There are good and bad guidelines on teaching cultural diversity, the main challenge I think lecturers face is to find good guidelines as they only appear to be few of them" [SL7]*

Moreover, some senior lecturer participants reported that the information on models and frameworks which is available is not relevant to the educational systems both in terms of legislation, policies and historical underpinnings as revealed by the comments below.

*".... A handful of some of those frameworks are not applicable to this country in terms of historical reasons for having them, ..... they are not always compatible with our legal and professional system..... they are good to the American and Australian systems...."[SL1]*

Senior lecturers in this study pointed out that they preferred to have models and frameworks of cultural competence that are developed from the historical framework of existing policies, regulations and legislation. They further stated that knowing the legal mandates that impinge upon their health systems may enable educators to be better prepared not only to comply with those policies, legislation and regulations but also to realize why such policies, legislation and regulations exist and what remains to be done. The comment below supports the assumption made.

*“.....tend to teach from an evidence based system, we need to know why in the first place those guidelines are there and where do we start ..... where do we end .....what are the signs that we have reached our intended destination.....”[SL4]*

In addition, the senior lecturers in this study felt that the university library books are limited or unavailable for them to use and also the problem is worsened because their mental health nursing students have no access to inter-library loan facilities as illustrated by the following comments.

*“Of cause we have access to interlibrary loans which one can possibly use if he or she is lucky, however, such books or materials can take up to two weeks to arrive from wherever they come from, however students don’t have such access and the budgets are tight...” [SL3]*

*“I have come across a peer reviewed article with inaccurate information about my own culture, and how can I use such an article as a reference or guideline to teach about cultural needs of patients who share the same background as me?” [SL6]*

Some senior lecturer participants in this study mentioned their lack of knowledge and expertise to teach cultural competence and some openly admitted that they generally feel ill-equipped to teach cultural sensitive topics and anti discriminatory practice in mental health as illustrated by the comments below.

*“I personally feel that as senior lecturers we are ill equipped to teach cultural sensitive topics and issues related to anti discriminatory practice in mental health” [SL9].*

*“It’s not all of us who are competent to teach diversity, however, if there is need, surely we can try and find time to do a bit of research about it...” [SL2]*

Other senior lecturer participants in this study strongly warned about using the available library books and cultural competence materials which they reported to be superficial and lacking the depth needed. The comments below illustrate their concerns.

*“People need to be careful on what they read and teach students, because there’s a lot of misleading and stereotypical information out there” [SL4]*

*“A substantial bit of what I teach involves a lot of consideration of the cultural needs of diverse people and you would find that our libraries are staffed with American and Australian staff which in most cases seemed to be irrelevant here” [SL1]*

*“A lot of textbooks you find in our libraries provide insufficient information that has the potential of leading us to teach stereotypical views of some cultures” [SL5]*

Other senior lecturers felt that there is need of proper guidelines and materials to assist them to properly teach cross cultural issues within the mental health nursing curriculum as illustrated by the comments below.

*“There are good and bad guidelines on teaching cultural diversity, the main challenge I think lecturers face is to find good guidelines as they only appear to be few of them” [SL7]*

*“If anyone or you can come up with good guidelines for us to use, I think it will be great and make our lives easier” [SL5]*

Although parts of some cultural competence teaching resources such as models and frameworks of cultural competence are being used by educators, the study findings seem to suggest that they are not universally and uniformly applied across all the universities that participated in the study as demonstrated by theme two of this study finding. Furthermore, such resources are reported to be irrelevant to the UK systems. Such findings suggest that even if the senior lecturers are willing to incorporate cultural competence in the curriculum, there could be some factors which hinder them to do so, such as inadequate teaching resources, limited or no guidelines and also their inadequate knowledge on what to include. Therefore the theme of **educator’s subject expertise and scarce resources impact on cultural competence education** emerged.

#### **4.7: Theme 7: Develop educational programs that respond to cultural diversity**

Another theme that emerged from the current study is that the participants felt that there is need for educators to **develop educational programs of cultural competence using educational materials and approaches that respond positively and constructively to cultural diversity** of students.

By carefully considering the mental health nursing students make up from the universities that participated in this current study, it was evident that there was a vibrant mixture of diverse student groups in terms of ethnic, racial and cultural plurality within the mental health student groups. As a result of the changing diversity in classrooms, study participants expressed the need for senior lecturers to shape their curricula to be culturally responsive to the needs of students using cultural sensitive materials to broaden the way in which the term “culture” is conceptualised and how images of cultural groups are portrayed within the curriculum. The following comments made illustrate the assumptions.

*“As a lecturer in a culturally diverse classroom, I would prefer the university to fund the courses that will enhance my cultural sensitivity, so that I’ll be able shape the curriculum to be culturally responsive to my students” [SL1]*

*“Majority of the time the books and materials recommended by our lecturers are dominated by information that support the supremacy of the Western cultures as number one” [SN5]*

Some senior lecturers suggested that providing a diverse learner focused environment could be the answer to reduce racial tensions in class especially where their current classes have high proportions of ethnic minority students enrolling into the mental health nurse training. The following comments illustrate such claims.

*“..... one of my classes has got more than half students who are non White and majority of them from Africa..... one way I tend to do to reduce racial tensions in class during cultural discussions is to bring statistics and references so that students don’t feel intimidated.....” [SL2]*



*“ ...To minimise such racial tensions in class, I think lecturers are supposed to make sure that the curriculum materials, textbooks and other resources used in classrooms should clearly produce meaning and define what’s appropriate in promoting social relations among diverse student groups” [SL7].*

*“.....it’s about the content and the direction of lesson that cause racial disruptions..... Once you give ground rules in your class, there is unlikely to be any racial disruptions.....” [SL3]*

Some senior lecturer participants in this study felt the need of proper framing of the teaching and learning content of cultural competence within the curriculum to make it more relevant and culturally responsive to the diverse students in their classrooms. The following comments represent their views.

*“I would introduce literature including equitable representations of diversity through the use of educational materials that are culturally sensitive to my diverse student groups” [SL9].*

*“Knowing the cultural background of my students and developing my cultural sensitivity through attending relevant professional development courses in cultural diversity will be a crucial part of teaching in the classroom” [SL6]*

*“I think students' self esteem and moral can be boosted by culturally responsive curriculum” [SL3].*

Even the student sign-off mentors and the clinical mentors agreed that keeping the different cultures within the familiar and friendly framework of the curriculum will more likely hold the students' interest in learning about other cultures which could enhance their self esteem to freely discuss openly about their own cultures without fear. Such claims are illustrated by the following remarks.

*“I think lecturers must include in their teaching,... the various positive contributions made by people from different parts of the world to this country” [CM2]*

*“The mental health nurse curriculum should include content about the cultures and contributions of many ethnic groups to the society using a variety of teaching techniques that are culturally responsive to different ethnic learning styles within the classroom environment” [CSM2]*

From such assumptions, views and comments from the study participants, it is evident that a multicultural learning situation brings with it a number of challenges that need to be overcome in order to create an effective learning environment for every student. Such comments also suggest that the changing profile of the student nurses backgrounds necessitates a change in the approach to teaching cultural competence. This also requires approaches to teaching and learning that includes students' cultural references in all aspects of learning.

#### **4.8: Theme 8: Incorporate relevant critical reflective educational strategies**

Related to the theme of “**developing educational programs of cultural competence using educational materials and approaches that respond positively and constructively to cultural diversity**”, another theme emerged in this study requires senior lecturers to **incorporate educational strategies that are conducive to critical reflective dialogue among diverse learners** when addressing issues of cultural competence within the curriculum.

From interacting with study participants and observing the curriculum documentation materials used by senior lecturers, it appears that the teaching and learning strategies (pedagogical models) in pre-registration mental health nursing programs are constantly being developed and refined to assist students in absorbing content on the nursing care needs of diverse culturally population they serve. Most senior lecturers in this study reported using a wide array of pedagogical models and strategies when addressing cultural competence within the curricula. The pedagogical models used include but not limited to intergroup dialogue, the use of experiential learning activities, cognitive processes such as classroom based teaching, case studies, the assimilation model, self-exploration and the antiracism model. The following comments illustrate how educators incorporate a range of teaching and learning strategies that are designed to help students develop cultural competence skills.

*“ ..... when I’m addressing issues of culture and its impact on mental health, I find it helpful to put students in let’s say two groups to research about particular topics then invite the groups to do some intergroup dialogue about their findings which I find my diverse student groups welcoming such discussions well.... ”[SL5]*

*“I sometimes give my students scenarios for example, one of the scenarios I gave them was of an Afro Caribbean young man who was experiencing signs of schizophrenia living with parents who were dedicated Christians..... I asked learners to identify possible causes of his illness, and possible nursing interventions ..... Obviously I would expect the students to link the attributes of somebody from an Afro Caribbean background on their discussions from assessments to interventions..... ” [SL6]*

Another senior lecturer demonstrated how he incorporates inter group dialogue by combining it with case scenarios when addressing issues of cultural competence in class.

*“In Birmingham we have got a lot of people from cultural different backgrounds. I sometimes ask my students to do case studies of a culture different from them to find more about their history, origin, faith, religion, values, food, dressing, rituals and so on..... I then ask students to come and present their findings to other students for example if one picks a Moslem culture, I would expect them to say in terms of food, Moslems would only eat Halal meat..... by so doing, the student would at least have some ideas that when they serve food to Moslems, they need to be cultural sensitive to the meat they give them.....” [SL1]*

Other senior lecturers in this study mentioned that majority of their students who come for nurse training are adult mature students and therefore, they suggested that the best way adult students tend to acquire knowledge is through transforming it from experience. They therefore implemented experiential learning as one of the essential pedagogical approaches to be used when addressing cultural competence within the curricula. Their comments below illustrate such claims.

*“ ... in addition to teaching students about different cultures and how they affect the understanding of mental health and well being, I personally feel that the experiential learning we expose our students during their clinical placement is more important. ....” [SL2]*

*“... to me there is no wrong or right approach. Both experimental learning and traditional based classroom training when it comes to training students to nurse diverse people are all ok. I think each complement another....” [SL4]*

*“..... I do support the traditional based classroom teaching, however, but in nursing, some aspects cannot benefit from the classroom teaching setting, and I think cultural competence is one of them ..... therefore sending the students for clinical placement to feel how those different cultures expect the nurses to treat them I think will be more beneficiary” [SL8]*

As one of the practical ways of equipping the nursing students with cultural competent skills a number of participants in this current study suggested the use of case scenarios by examining real or simulated multicultural nursing care issues and problems, the rationale being that learning could take place through the discussion of each cultural facets. Below are some of the comments

which support the use of case scenarios as one of the pedagogical methods to be incorporated when addressing cultural competence within the curricula.

*“I also employ case scenarios which I find useful when it comes to transfer theory into practice”*  
[SL5]

*“As part of my teaching on different nursing care issues including cultural issues, I tend to use case scenarios where students will discuss appropriate responses to situations and to consider how potential cultural care needs of patients’ could be met”. [SL1]*

The student clinical mentor also supported the use of case scenarios when addressing issues of culture as commented below:

*“...the cultural nursing care needs of patients from diverse backgrounds can be integrated into the core curriculum by a number of ways ..... such as having case scenarios which specifically demands the knowledge and skills of diversity..... For example, one might give students case scenarios in which cultural difference acts as an obstacle to the assessment, planning and implementation of a programme of care. Such case scenarios have ability to develop a participatory decision making style on students to how issues of culture impact the whole care delivery.....”* [CM2]

Surprisingly, some participants from senior lecturer participants and student nurse participants in this current study also regarded the assimilation model as one of the absolute ways of addressing the nursing care needs of patients from diverse ethnic backgrounds. The study participants who favoured the assimilation model viewed the nursing care needs of people from ethnic minority backgrounds as deviant and encouraged them to acculturate to culturally dominant majority White norms. For example, one student nurse gave this comment:

*“...if you go to Rome, you are expected to do what in Rome the Romans do. Why should it be that when people come to Britain, they expect the British to be experts in those foreign cultures? ... isn’t this unfair and an extra burden to our society...”* [SN7]

Another student from the focus group discussion gave this emotional view:

*“ .... Before these patients come to Britain, they were at least supposed to think of what could be the consequences when they become ill. Obviously we’re not expected to know their single cultural norms in order to be good nurses. People who want to come to England need to know that they are going to England where English people speak English and nurses are not expected to learn their vernacular languages just for the case of trying to nurse them. .... in my opinion, I think issues of language barriers should not be a burden for the nurses and nursing students, but for the patients’ families... that is if they wish their own relative to be treated by British Nurses ....” [S3FG2]*

The same sentiments were supported by another student in the same focus group:

*“.....we didn’t come here [to the university] to spent majority of our time learning about providing excellent nursing care to foreigners only ..... if we spent such a substantial amount of time learning about their needs, how much time are we supposed to spend learning about the indigenous White British people who are the majority? .....”. [S6FG2]*

One of the senior lecturer participants seemed to typically support, encourage and teach this assimilation model within the pre-registration mental health nurse training when addressing cross cultural nursing care issues within the curriculum. The lecturer gave this comment:

*“.....If people want to base on statistics, then they I think we are doing much more in terms of addressing the care needs of foreigners and other non White British people. Whether you want to say the last census gave the population of the ethnic minority to be 6% or 10%, then I think we are putting more than 10% effort in trying to address the care needs of these ethnic minority people ..... these reports such as the Bennett Inquiry they say what their authors wanted to say ....” [SL4]*

In addition, study participants were asked about how they would prefer to receive cultural competence education within the curriculum. The findings of this type of question seem to suggest that the most preferred methods of delivering cultural competence training by participants are case studies, lectures, having guest and expert speakers coming to deliver some cultural competence specific areas within the curriculum. The following comments illustrate their preferred delivery methods.

*“We learnt much about being culturally sensitive when interacting with community members who were involved in the delivery of the curriculum”. [SN1].*

*“..... there is no better way to develop understanding of a culture than to live within it”. [SL3].*

*“If we involve ex service user to come and deliver the lesson, we also as lecturers learn from them and devise future guidelines on what to teach based on their needs”. [SL2]*

*“We have learnt and gained as much as possible about some of the community members’ culture from the ex service users who participated in some of the lectures” [SN3]*

*“We have in the past invited nursing practitioners from diverse backgrounds to come and teach their areas of expertise and we will continue to engage cultural competence experts if our budgets allows” [SL6]*

However, it seems that the type of delivery method varies according to the student make up in classroom environment in terms of cultural backgrounds and the topics being addressed as already discussed in themes 6 and 7 above.

Such findings suggest that the pedagogical models used by educators share essentially the same goal, but differ in the strategies used to attain them. Therefore, these findings suggest that senior lecturers may need to **incorporate educational strategies that are conducive to critical reflective dialogue among diverse learners** in order to develop cultural competence skills within the curriculum.

#### **4.9: Theme 9: Engagement of multi-professional experts to assist in teaching culturally competence specific areas**

From interviews with study participants from both groups of educators and third year mental health student nurses, it was evident that **engaging local population, service users and experts on cultural competence to assist in teaching culturally competence specific areas** is one of the better ways of developing the understanding of the needs of diverse cultures within the pre-registration mental health nursing curriculum.

The importance of involving the local population such as the community leaders and the service users was arguably one of the strongest themes to emerge from both participants. The participants felt that *“there is no better way to develop understanding of a culture than to live within it”*. [SL3].

Majority of the participants in this study advocated the need to engage local people coming from those diverse cultural groups to come and interact with student nurses as part of the guest speakers within the mental health nurse curriculum. Those participants insisted that local people could be better experts to give a general view of cultural expectations of the communities they represent. Some of the comments which support such claims include:

*“.... having a community member and or the mental health service user, working and interacting with the students as part of the guest lecturer provides nursing students with an increased opportunity to learn more about the cultural nursing care needs of those represented.”* [CSM2].

*“I think a curriculum that has meaning in terms of addressing the needs of diverse communities has to connect and engage the support of people from those diverse cultural groups, for instance at least engaging or involving respective community leaders as they are in much more position to define some of the community needs.....”* [CM1]

*“In nursing if you’re not sure you need to ask, therefore, if our lecturers are not sure or confident of addressing some of the cultural care needs of diverse patients they also need to ask those local people to come and give us a talk”* [SN5]

*“.... there is no better way to develop understanding of a culture than to live within it”*. [SL3].



Some participants in this current study suggested liaising with some of the community leaders to come and give talks to student nurses about some of the mental health needs and understanding of their communities including talking about how they preferred those needs to be addressed by nursing staff when they are unwell. The rationale for inviting members of different communities to come and deliver lessons was that it would provide students with opportunities to see how different cultures within the communities view mental health issues as illustrated by the comments below.

*“..... one way the university can do is to have some budget for external visiting people such as community leaders and other cultural experts to come and give a talk to students about their cultures, their expectations when members of their families are unwell, and how they preferred the nursing staff to provide nursing care to those family members. .... this is possible although might not fit well with some of the budgets.....” [CSM2]*

*“Why not invite some good spiritual leaders and pastors from the local communities, at least they can make a difference and after all they are used to teaching big crowds .....” [SN7]*

*“ ..... by inviting members of different communities to come and deliver lessons, students will be able to see how different cultures within the communities view mental health issues”[SL5].*

In addition, some senior lecturers in this study reported that they engage local populations and cultural competent experts to come and deliver cultural competence specific areas as a way of for providing support for senior lecturers and equipping students with knowledge from diverse perspective as illustrated by the comments below.

*“Within this university, we tend to invite a lot of ex service users’ and interested members of the community or practice nurses to come as guest lecturers and some are also responsible for identifying and providing support for lecturers when addressing issues of cultural competence within the curriculum” [SL7].*

*“..... these community members and service users are not the source of cultural competence knowledge and skills, but, rather, are partners in planning for their communities’ general needs.....”. [SL6].*

*“..... although I don’t believe that we can teach our nursing students to become cultural competence practitioners, however, I strongly believe that if we can sought out and engage such*

*cultural experts like Dxxxxxx Sxxxxxxx [named professor and expert in cultural competence], our student could possibly gain much more than from most of the lecturers like myself who are nine out of ten not really competent in the subject.....” [SN9]*

One clinical student mentor participant in this study also strongly recommended the involvement of even less educated community leaders to be engaged as visiting lecturers to address the care needs of diverse communities. The clinical student mentor gave this comment:

*“..... instead of always seeking out and engaging only those with PhDs and Masters to come as visiting lecturers as they used to do during our training, I would recommend if the universities can now take it as an opportunity to involve the less academic ones such as community leaders to come and address the mental health care needs of their communities. .... Community leaders hold the influence of making their followers engage or disengage with the services..... having the knowledge that nurses are also being trained by community leaders could have an impact on how services are perceived by the public.....” [CSM1]*

A number of study participants from student nurses, senior lecturers and clinical mentors also considered strengthening community connections as a major goal for the universities that offer mental health nursing training. Some of the senior lecturers interviewed expressed that they are continually trying to strengthen links between the university and the communities served as a way of working in partnership with the local people and also as a way of gaining some knowledge from them. The following comments illustrate such claims.

*“..... these community members and service users are not the source of cultural competence knowledge and skills, but, rather, are partners in planning for their communities’ general needs.....” [SL6].*

*“.... by inviting members of different communities to come and deliver lessons, students will be able to see how different cultures within the communities view mental health issues” [SL5].*

*“..... if we involve ex service user to come and deliver the lesson, we also as lecturers learn from them and devise future guidelines on what to teach based on their needs .....” [SL2]*

One mental health course leader participant was popularising the expression that:

*“ ....when things go wrong in mental health nursing practice, the government and the public witch-hunt into the training institutions just like what happens with Stephen Lawrence and Rocky Bennett..... ” [SL6]*

As a result of such local population involvement, some student nurses in this study reported to have learnt a lot in terms of the care needs of diverse communities as illustrated by the comments below.

*“.....we learnt much about being culturally sensitive when interacting with community members who were involved in the delivery of the curriculum..” [SN1].*

*“....we have learnt and gained as much as possible about some of the community members’ culture from the ex service users who participated in some of the lectures” [SN3]*

However, some of the senior lecturer participants were bit defensive to why they do not always involve local people in the delivery of the curriculum. Their reasons were centered on the budgets and also the belief that if members of various minority groups are consulted, they may be viewed by students as speaking for the specific entire group membership they would be coming from. The comments below represent such claims.

*“..... we do want to engage everyone who has some expertise, however sometimes it’s not that easy as people might think, we have to consider financial resources among other things...” [SL2]*

*“.... it sound quite good to invite community leaders to come and talk about their own cultural groups expectation, however, the danger is that the student might view such talks from community leaders as representing their entire cultural memberships” [SL1]*

*“..... cultures are not static and I see no much benefit in engaging community leaders to be part of our team” [SL4]*

Some senior lecturer participants stated that consulting with community leaders and members of the local community in the teaching process was simply demanding and time consuming. The following comments illustrate such claims.

*“Although it might helpful to consult or ask senior community leaders to come and help us deliver, however, one has to realise that in practice, it might be difficult to consult those community leaders and also demands time” [SL5]*

*“..... due to our focused budgets and time it’s not always possible to invite community leaders to come and teach students about cultures in general as they’re themselves not experts in cultures in general with probably the exceptions of their own cultures..... ” [SL8]*

Some senior lecturer participants were of the opinion that although educators might want to involve community leaders and other local cultural group experts, they are still challenges they may face such as approaching some members of the communities who may not appreciate the value and potential benefit of consultation, as illustrated by the comments below.

*“..... as lecturers how do we select the appropriate and the willing members of the community to come and deliver such lectures?” [SL1]*

*“..... although it sounds a good idea to invite the community leaders, however, there is always that danger ..... that possibility that some members of the community might not appreciate the potential benefit of consultation and might not be willing to be consulted”[SL3]*

Some participants felt that student nurses should be equipped with those skills necessary to work with only the local populations they serve.

*“.... nurses must be trained at least to understand the artistic expressions of major client groups they serve” [CM2]*

Some senior lecturer participants appear to have a negative view of the willingness of engaging the community leaders in the teaching process citing that their budgets would not allow them such flexibility. Other senior lecturer participants felt that engaging cultural competence experts as part of visiting lecturing instead of community leaders or members of the community was more than enough. Comments below illustrate such views.

*“..... we do want to engage everyone who has some expertise, however sometimes it’s not that easy as people might think, we have to consider financial resources among other things” [SL2]*

*“..... we have in the past invited nursing practitioners from diverse backgrounds to come and teach their areas of expertise and we will continue to engage cultural competence experts if our budgets allows” [SN6]*

*“..... due to our focused budgets and time it’s not always possible to invite community leaders to come and teach students about cultures in general as they’re themselves not experts in cultures in general with probably the exceptions of their own cultures.....” [SL8]*

*“I don’t think that the idea of inviting community leaders and other members of the local community to come time and again to deliver cultural diversity to nursing students as a good idea especially within this university considering the current budget constraints” [SN7]*

In addition, from interviews with senior lecturers and student nurses who participated in this study, including observing the curriculum documentation used in the curricula such as time tables, module guides, lesson notes and handouts, there is a lot of evidence to suggest that some universities are also drawing service users, ex-service users and cultural competence experts and visiting lecturers into the university to contribute to student learning through providing external talk lectures. However, community leader input into the big picture of the nursing curriculum is not a strong focus or practice. Furthermore, it appears as if most decisions about culture and how it is approached within the curriculum seemed to be made by individual senior lecturers.

#### **4.10: Theme 10: Integrate cultural knowledge into the curriculum as an extensive general framework**

One of the questions that the researcher asked each and every participant in this study was about the study participants' preferred cultural issues topics to be included in the curriculum. Many of the participants from among the student nurses, clinical mentors and sign-off mentors felt that the curriculum should at least focus on the cultural care needs of the local population, while almost all the senior lecturer participants were very clear on what not to be taught in order to avoid homogeneous cultural assumptions. As a result, one of the themes to emerge was the need to **integrate cultural knowledge into the curriculum as an extensive general framework.**

Study participants from both educators and students expressed differing views on the usefulness of knowledge about specific ethnic groups. For example, some student nurse participants stated that they found it useful to acquire cultural knowledge of specific cultures as it helped to contextualize the individual's experiences as exemplified by the comment below.

*".....having learnt about the histories of the Somalis in Britain helped me to contextualize their experiences ....." [SN8].*

Other study participants from the students mentioned that they have engaged in contact with external speakers from some religious groups which they have acquired such background knowledge as shown by the comment below.

*" ..... we benefited a lot from Moslem religious leaders who came and gave us a lecture about how Moslems preferred to be looked after from being sick upto death and dying...." [S2FG2].*

A few nursing student participants took the position that prior knowledge about specific groups was not essential, and could serve to introduce inappropriate generalizations and stereotypes.

*"....people are unique, cultures are also unique hence teaching us about major cultures in this country will only make us generalize people and stereotype them... [S2FG1].*

Additionally, a number of third year mental health nursing student participants in this study felt that they would benefit a lot if their educators were giving them more information about specific cultures of their local populations. Below are some of the students' comments made to illustrate the point:

*"I know it's difficult to teach us about the care needs of everyone, however, they must teach us about the basic cultural needs of the major cultural groups around us" [SN2]*

*"Of course the world has probably millions of cultures, but why not teaches us about those common ones" [S5FG2]*

*".... if I were a lecturer, I would teach students information about specific cultures within the UK" [SN3]*

*"Birmingham is such a diverse city, however, why can't they teach us about the major cultures and ask us to research about the rest" [S3FG2]*

*"I think I would teach learners about the major specific cultures that are mostly found on the placement settings such as Moslems, Afro Caribbean, and Sikhs and so on" [CM1]*

*"..... I would teach student about cultural diversity and how to respect the cultural differences if I was one of the lecturers" [CSM1]*

One of the senior lecturer participants also supported the student assumptions of the need to have information on cultures of local populations as illustrated by the comment below.

*"In Birmingham we have got a lot of people from cultural different backgrounds. I sometimes ask my students to do case studies of a culture different from them to find more about their history, origin, faith, religion, values, food, dressing, rituals and so on..... I then ask students to come and present their findings to other students for example if one picks a Moslem culture, I would expect them to say in terms of food, Moslems would only eat Halal meat..... by so doing, the student would at least have some ideas that when they serve food to Moslems, they need to be cultural sensitive to the meat they give them....." [SL1]*

The usefulness of generic knowledge about cultures as well as group specific knowledge about culture was valued by a number of study participants from both educators and student nurses as a

way to contextualise an individual's perspectives. The comments below demonstrate such assumptions.

*“ .....it's a question of balancing between generic and specific cultural knowledge that we give students ..... obviously too much or too little has its consequences...” [SL5].*

*“ ..... we had lessons in sociology of health and illness where we learnt about inequalities in health in terms of class structure, ethnicity, social class, races and so on.....” [SN4]*

Whilst majority of the student nurse participants and, student clinical sign off mentors in this study felt the need for senior lecturers to teach the nursing students about specific cultural groups within the curriculum, however, few of those participants recognized and acknowledged the impossibility of teaching student nurses about all the cultures on earth. The following comments illustrate such acknowledgements.

*“It won't make any difference to me to teach students about specific cultures .....Even in the very unusually small cultural groups; there is great diversity among individuals” [CSM2]*

*“..... even if the lecturers decide to pick and choose let say some of the cultural groups within the UK society, still they can find themselves discriminating those minor groups that will be left out....” [S4FG2]*

However, majority of senior lecturers in this current study were quite adamant about having to teach student nurses basing their information on specific needs of particular cultures. Those senior lecturers felt that if they aim to give information on specific cultures when addressing the care needs of diverse cultures, they will promote stereotypical views on the students which might make students think that cultures are homogeneous and discrete. The quotes below illustrate their claims.

*“..... as an introduction or an initial step for students to learn about cultural competence, I would say yes.... it could be helpful to teach students about specific cultures, however, it is important to be aware of the stereotypical views that students can build which could end up being towards cultural incompetence” [SL1]*



*“..... although it sounds more practical to teach students the facts about specific cultures, however, there are risks that students might take those facts and use them to stereotype their diverse client groups” [SL2]*

*“I have come across in many instances where students view a culture as a homogeneous system shared by members of the society and therefore expect it to be something that can be separated and distinguished from other cultures. This is however not the case, cultures to me are quite dynamic and students need to be taught that is not the case” [SL3]*

*“I don’t agree with those who say that we should teach students about specific cultures or cultural norms. First cultures aren’t homogeneous and therefore people don’t have to make assumptions..... Secondly, they aren’t any specific cultural norms because cultures aren’t static but are very dynamic and acculturation is always influencing people’s beliefs” [SL4]*

One senior lecturer participant totally disagreed and found it strange and impracticable that educators should focus on specific cultural needs of local population as a way of preparing student nurses to be cultural competent. The senior lecturer gave this comment to demonstrate his disagreement:

*“..... I find it very strange and impracticable to teach students about what they perceive as the common cultures around even Birmingham. Just one individual client can have more cultural influences that might need to be addressed and that it may be impossible for any lecturer to teach about the particularities of all the different cultural groups found in Birmingham alone yet in the UK” [SL6]*

When asked why the senior lecturers think it was not a good idea to teach students about the nursing care needs of local population, some senior lecturer participants gave the following reasons:

*“..... preparing students to be cultural competent is not about teaching students about specific cultural groups which in my opinion those specific groups don’t exist” [SL7]*

*“Cultural competence is an ongoing learning and acquiring of skills and specific competences about working with cultures and their acculturations and it’s not something that can be validated by being put into a specific two week course or passing an assignment or test” [SL4]*

When one of the senior lecturers in this study was asked by the researcher whether she agreed with the notion of focusing on specific major cultures within the local communities as a basis for teaching student to become cultural competence, she gave this comment:

*“ .... I don't agree and believe that any lecturer can teach any student to become cultural competent..... secondly as cultures do not exist in vacuum, therefore, cultural competent cannot be taught as a set of unchangeable facts.....cultures change with time, preferences.....societal expectations, .....even politics or the legal system of the country can force certain cultures to change their traditional habits such as arranged marriages in Western societies for example.....”[SL3]*

Another senior lecturer gave an overwhelmingly reason to support the reasons why they do not have separate modules to teach students cultural competence. His argument was that students need to focus more on the patient as a whole and the issues of culture will arise to be obvious. The senior lecture gave this comment to illustrate the point made:

*“.....because cultures do not exist in isolation to the patient, therefore it's very important for our student nurses to look at their patients holistically and that is probably one of the reasons we try to avoid teaching our students separate cultural diversity care modules.....”[SL2]*

Another senior lecturer suggested using different scenarios when integrating cultural knowledge into the curriculum as a way of informing the nursing students of the diverse and uniqueness of clients needs in order to avoid homogeneous cultural assumptions. The following comment illustrates the point made:

*“As part of my teaching on different nursing care issues including cultural issues, I tend to use case scenarios where students will discuss appropriate responses to a situations and to consider how potential cultural care needs of patients' could be met” [SL1]*

A clinical sign-off mentor participant supported the idea that it would make no difference in teaching students about specific cultural groups as diversity will still exist within such groups. The clinical sign off mentor gave this comment:

*“It won't make any difference to me to teach students about specific cultures .....Even in the very unusually small cultural groups; there is great diversity among individuals” [CSM2]*

When the researcher enquired from the study participants whether they should be specific modules or courses within the nurse training on cultural competence, some senior lecturers were even more adamant of having specific modules or course on cultural competence within the mental health nursing curriculum. One senior lecture gave this comment to illustrate the point:

*“..... whilst I don’t deny the possibility that the current nursing curriculum might need to be strengthened in terms of incorporating the cultural diversity teaching, however, at the same time I don’t agree on the one size fits all approach...”. [SL7]*

Other senior lecturer participants argued that the curriculum is already over stretched and that adding more courses are of no great benefit, as illustrated by the following comment.

*“I think the curriculum is already over stretched and that adding more courses is of no great benefit ...” [SL8]*

Other senior lecturer participants suggested that autonomy on what knowledge to integrate into the curriculum should rest within individual lecturers rather than trying to enforce it, as illustrated by their comments below.

*“.....Individual lecturers should still have the autonomy on what to include in the curriculum and how they prefer to deliver such teaching .... Remember teaching depends on what individual lecturers fill comfortable with. You once mentioned to me that during your research some lecturers felt uncomfortable to control escalating outbursts that arose from students during discussion of cultural issues. How then would you expect them to manage the situation if things are to be forced on to them.....?” [SL7]*

Conversely, other senior lecturer participants argued that although it might be important to have specific modules within the current curriculum on issues of cultural care, however, they suggested that doing so might be seen by learners as something which should be treated separately and “an add on extra burden” to what they learn in mental health nursing. One senior lecturer put this comment across to illustrate the claim:

*“ .... Yes from the layman’s point of view it might be seen as an important thing to have specific modules on cross cultural nursing care, but, who knows, whether students will take that module as*

*an add on extra burden to what they learn, or a separate entity which should be applied separately is something to be considered. ....” [SL6]*

In addition, nurse educator study participants suggested that the nursing students need to be equipped with the knowledge of the diverse people’s contribution to the society as illustrated by the comments below.

*“..... students’ awareness of the benefits and our interdependence of different people from around the world would sometimes reduce those mentioned tensions and some stinginess....”[CSM2]*

*“ ..... even simply talking about different food within the UK such as curry dishes will make students feel the benefits of our cross cultural borrowings...and exposes the students to some creative talents of people from different parts of the world who are now part of our society and their talented gifts are now part of our society....”[CMS1]*

*“ ..... we have got modules on diversity that provides insights into cultural diversity as a stepping stone towards cultural competence ....”[SL3]*

The findings of the above theme seem to suggest that although it might be seen as a good idea for the curriculum to focus on specific cultures of local people, however, the senior lecturers themselves in this study are warning about the dangers of homogeneous cultural assumptions that the students may build in the process and will end up believing that cultures have discrete concrete beliefs. Therefore, it seems that there is need to “integrate cultural knowledge into the curriculum as an extensive general framework” rather than in a specific module.

#### **4.11: Theme 11: The need for cultural competence education that focuses on effective cultural sensitive skills**

Study participants suggested that a cultural competent inclusive curriculum should address relevant cultural sensitive skills. For example, cultural sensitive skills that were identified by study participants as relevant include effective communication strategy, client centred approach, use of interpreters, building a therapeutic relationship with clients, reaching a shared understanding between staff and clients, addressing issues of holistic patient centred approach and subjecting nursing students to intercultural experiences. The comments below identify communication skills, use of interpreters and building a therapeutic relationship with clients as some of the cultural sensitive skills that the study participants identified as effective in their curricula.

*“..... We had sessions on effective communication skills and language needs where we were given assignments to reflect on or interpersonal relationships with clients whose first language was not English....” [SN7]*

*“ ....we thoroughly discussed and critically examined the use of interpreters .....” [SN2]*

*“I would say in each and every module studied, students are taught the different skills of communicating with different patient groups which includes the deaf, those whose first language is not English or where clashes of accent co exist...” [SL8]*

*“ ..... we encourage and give students the opportunity to work with named clients so that they build a therapeutic relationship by sharing some personal information with that particular client ... and this will also facilitate some trust” [CM2].*

Other study participants expressed a need for pre-registration mental health nurse training curriculum to put more emphasis on the communication and language needs of diverse cultural groups within the society, with many of the participants stating they would like the opportunity to undertake education and training that focuses specifically on effective communication strategies and building a good rapport with clients. Below are some of the participants' comments that illustrated the assumptions made.

*“I think communication is one of the important care needs of patients from different cultural backgrounds and we would like more of those sessions” [SN2]*

*“I have come across many of my students who are very good communicators but when it comes to work with clients, they cannot develop proper rapport with clients... I think this is a skill which probably needs to be addressed within the classroom setting by their lecturers” [CM1]*

*“I sometimes ask students from different backgrounds to come and role play the nurse-patient interaction which I believe is one of the ways we train our students some skills of cultural competence” [SL5]*

*“As nurses we need to carefully listen to the accents of the patients and we also need to talk slowly and loudly especially if we have got different accent from them” [SN3]*

Both the interviews and focus groups findings suggest that student nurses who are from ethnic minority backgrounds whether British or not, including those from White indigenous British student nurses, may require different communication skills as part of the core cross-cultural skills required for culturally competent nurses. The comments below illustrate the claim.

*“Some of our clients came from far places such as Kosovo and without any clinical history at all ..... Some student nurses tend to struggle when it comes to client history taking; therefore I think it might be helpful if their training also prepares them more when it comes to interviewing clients especially for the first time. ...” [CM1]*

*“Some clients just want to be listened to so nurses should have skills of good listening without interruptions” [S1FG2]*

*“Quite a number of students tend to struggle in terms of demonstrating in their assignments on how they provided patient centred care to their clients” [SL5]*

Some study participants mentioned that student nurses should also be trained the interviewing skills as one of the essential components of cultural competence when working with diverse mental health clients. The following comments illustrate the claim.

*“..... some cultures, if interrupted when they are talking during interviewing them, they become upset or aggressive, therefore you need to listen to them attentively” [S3FG2]*

Some participants felt that student nurses need to be equipped with some skills of negotiating any aspects of the patient care from care planning, implementation and reviewing, as illustrated by the comments below.

*“Mental health nurses need to be trained on how to negotiate with the clients during care planning, implementation reviewing ...” [CM2]*

*“It is important that we equip student nurses with the skills of discussing any treatment plans with the clients and then negotiate the plans of care with clients and their families or carers” [SL8]*

From the clinical practice where student nurses are assessed for their clinical competence, clinical nurse educators in this study reported that some finally year student nurses lack the negotiation skills when it comes to care planning. The comment from the Clinical sign off mentor below illustrates such as short fall.

*“I have come across some third year mental health nurses who aren’t aware that the care plans should be a result of a partnership in decision making between the nurse and the patient” [CSM1]*

These study findings also suggest that communication, negotiation, working in partnerships are fundamental components of cross-cultural care encounters and that the curricula need to address such deficits to ensure that mental health student nurses are equipped with the necessary cultural sensitive skills to provide quality care to patients from different cultural backgrounds. The comments from the student nurse participants below also stress the need.

*“my previous clinical placement had patients from different ethnic, racial and cultural backgrounds and I gained a lot of skills and knowledge from them during our interactions” [SN5]*

*“Some of the patients when they develop mental health problems, they will loose their ability to speak in English and therefore would need interpreters” [SN1]*

In addition to the mentioned skills above, the study participant also suggested that the mental health nurse training curricula should focus on or try to address issues of holistic patient centered approach when addressing cultural competence within the curricula. For example, one of the senior lecturer participants gave this response to illustrate the point.

*“One of the issues we tend to focus on when teaching students to nurse diverse patient groups is to be patient focused rather than focussing on the patient’s cultural background..... If the students put their focus on the client’s needs, then automatically the issues of culture will emerge automatically and they can take on board holistically and not in isolation..... However, if the student put more emphasis on the patient’s culture, the nursing care outcome is mostly likely to be influenced by cultural prejudices... .”[SL5]*

When asked by the researcher how the senior lecturer participants preferred the patient centred care to be addressed within the curriculum, the same senior lecture has this to say:

*“... lecturers are different and each one is free to have their own approaches. My own approach when addressing the nursing care needs of diverse patients is by using the patient centred focus approach. By using the patient focus I will be able to teach my students ways of viewing the patient as a whole rather than their cultural backgrounds or their illnesses. By taking such a holistic view of the patient, then automatically the patient is empowered to discuss their own illnesses as they experience them..... obviously in turn, the patient would be able to give a clues to the nurses about their cultural beliefs and how such cultural beliefs influences or have an impact on their health”[SL5]*

Other study participants have these comments to say when emphasising the need of addressing issues of holistic patient centred approach:

*“No matter whatever cultural background the patient comes from, the patient must be the judge to their own care..... Within the curricula, I think students need to be taught different ways of empowering patients to negotiate and decide their own nursing care.....” [CSM1]*

*“..... quite a number of students tend to struggle in terms of demonstrating in their assignments on how they provided patient centred care to their clients” [SL1]*



*“..... I think lecturers have to step their efforts and try to teach students better skills of providing holistic patient centred care to their clients. To me each patient is diverse and has his or her own worldviews about a particular condition or illness and such world views could be influenced by their social environment or religious beliefs.....” [CM2]*

Another clinical sign-off mentor participant suggested that one of the important elements to be addressed within the curriculum in order to prepare student nurses to be cultural competent is to give more focus on the patient and their family as they are in a much better position to identify and understand their needs. The following is part of his speech to illustrate the point made.

*“..... when planning and implementing any nursing interventions, students are supposed to know that the centre of the focus is the patient and their immediate family.....this is because the patient and their family are in a better position to identify and understand their cultural beliefs and influences that affect their mental health and recovery.....” [CSM2]*

The student clinical mentor participant gave this response to illustrate the same point:

*“.... From working with nursing students in a cultural diverse place like H\*\*\*\*\*, to me patient centred care is the key to cultural sensitive care, hence strategies to teaching patient centred care must be a must in the curriculum if students are to be equipped with cultural sensitive nursing care skills.....” [CM1]*

The skills of address issues of holistic patient centred approach closely linked to the skills of promoting effective communication strategies.

Further, study participants suggested that that one of the ways of building student nurses' cultural sensitive skills is through subjecting them to intercultural experiences during their clinical placement activities. They asserted that direct and meaningful experiences with people from diverse backgrounds, including those from black and other minority backgrounds will help them understand diverse people's care needs. The following comments illustrate the suggestions.

*“ ..... It's not enough to say students will be clinically culturally competent after giving them some information, lectures and other classroom based activities ..... They also need to be*

*exposed into the clinical settings where they get the opportunity to work with people from all backgrounds.. the dominant and the minorities backgrounds ....” [SL3]*

*“..... direct and meaningful experiences of students with clients from different cultural backgrounds will help them understand diverse health care needs of people.....” [CM1]*

The educator participants especially from the clinical side recommended nursing students to be allocated clinical placements that subject them to personal experiences with patients from diverse cultural backgrounds in order to better understand their own cultural identity through comparison and contrasting with other cultural groups.

*“ ..... the racial tensions you suggested to me that they are reported to be happening among students, suggests to me that student nurses don’t understand themselves ..... in order for students to understand themselves I think they need to interact with other people different from them. ... I think the best people to interact with first are for them to go to placements where they have the opportunity to freely interact with different clients from different backgrounds.....” [CM2]*

Study participant felt that intercultural experiences gained in clinical placements can help to reduce the anxiety experienced by nursing students in unfamiliar cross cultural encounters and thereby boosting their self-confidence when interacting with clients from different cultural backgrounds.

*“ .... In clinical placements students will have the chance to interact with patients from different backgrounds under the supervision and support of their mentors and will thereby gain confidence when they graduate ..... as they will be working alone with unfamiliar cultures.....” [CM1]*

It is therefore clear from the findings of the above theme that any cultural competence education and training provision must be highly relevant to cultural diversity of mental health student nurses and appropriate to the individual communication and language needs of patients. The skills of addressing issues of holistic patient centered approach as well as intercultural experience skills gained in clinical placements were also assumed by study participants to be vital. Therefore, from the views and opinions of the study participants, the need for cultural competence education that focuses on effective cultural sensitive skills is paramount.

#### 4.12: Theme 12: Promote cultural awareness

**Promoting cultural awareness by examining and reflecting on one's cultural background** was one of the themes that emerged from interviews with both educators' and student nurses' participants. Under this theme, the findings suggested that when developing and facilitating cultural competence within the mental health nurse curriculum, it is essential for both learners and nurse educators to begin the journey of cultural competence by examining and reflecting on their own cultural backgrounds and biases first.

For instance, study interviews with educators both from the clinical and the university settings suggested that student nurses need to be equipped with the explicit knowledge and understanding of "self-awareness" in order for them to be able to understand that one exists as an individual, separate from other people, with private thoughts. As a result, they suggested that any education that considers the needs of diverse cultural groups should start from self reflection. A number of senior lecturer participants described some of the strategies of self reflection they employ when addressing the issues of cultural competence within the curriculum, as illustrated by the comments below.

*".... one of the strategies I tend to use when addressing issues of culture in class is to ask students to consider their own cultural backgrounds and practices before attempting to teach them about other cultures [SL5]*

*"..... I find it better to start by giving students some work whereby they write about their individual and family cultural values, practices and beliefs before the lesson, then come the lesson, I would ask them to bring their anonymous pieces of work forward so that we can read for the whole class. By that I find that students would be able to see where their cultural values differ and are similar to other people" [SL1]*

One senior lecturer participant gave this comment on how she personally addresses the issues of cultural awareness by self reflection within the curriculum:

*“I particularly teach my students to be able to move from being culturally aware of their own heritage to becoming culturally aware of the heritage of others” [SL2]*

Some educators reported that student nurses must be encouraged to reflect on their own cultural background in order to develop the understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people. Below are some of the comments by educators to illustrate such claims:

*“.... I think one way to tackle the issue of culture within the university setting is to encourage students to reflect and examine their own cultural values and beliefs first in order to appreciate the cultural values and beliefs of others”[CM1]*

*“..... if people are able to reflect on their personal values and biases, obviously they will be able to understand and appreciate other people’s cultural values and beliefs which are different from them” [SL6]*

*“ . some of the mentioned tensions could be reduced if students are encouraged to express their own individual personal values and beliefs first in order to appreciate other people’s values and beliefs” [SL7]*

*“..... if students are equipped with the skills of self awareness, they will be able to understand and appreciate the cultural differences and similarities that exist within, among and between groups” [SL8]*

From interviews with nursing student participants, it was also evident that reflecting on one’s cultural background was not only an issue which student nurses need to do alone, but was equally a valid requirement for educators to have. Some students suggested that if educators are not reflecting on their own cultural biases during teaching, then there would be a potential of hindering the way cultural competence issues are addressed within the classroom setting. Students from the study reported some of the actions and comments made by their lecturers which upset them, which seem to suggest that the senior lecturers also need to reflect on their cultural backgrounds as well as students. The comments below seem to substantiate such claims.

*“I was upset to hear our lecturer repeatedly saying “White indigenous population” as if they’re no black indigenous populations” [SN5]*

*“..... it’s unfair when lectures give summary statements about the cultural beliefs of Africans as if Africa is a single country” [SN2]*

*“It gets deep into my nerves if lecturers time and again refer to Asians and Moslems when they give examples of cultures as if they’re the only cultures on earth” [SN3]*

These study findings suggest that this hindrance occurs because some lecturers may not be fully aware of the customs and practices of other cultures they address in class. By not being aware, they might say or do some things that offend the student which can hurt the success of the lessons centered on cultural competence as suggested by the above comments. Such problems of educators’ own biases are not as easily corrected because they involve the senior lecturer’s actions which the senior lecturer may not realize. One lecturer gave this comment to support the claim:

*“..... whilst it’s the right thing to encourage students to reflect on their self, it is equally true for educators to reflect on their own personal biases about some cultures .....” [SL3]*

Such comment from one of the senior lecturer participants suggests that possibly one of the ways the problem of senior lecturers’ biases could be addressed is when the senior lecturers realizes their inappropriate actions and biases and change them, as illustrated by the comment below.

*“..... if people are able to reflect on their personal values and biases, obviously they will be able to understand and appreciate other people’s cultural values and beliefs which are different from them” [SL6]*

In summary, the findings of this theme suggest that the promoting cultural awareness by examining and reflecting on one’s cultural background (self reflection) is crucial for both nursing students and senior lecturers within the learning environment. It is suggested in this study that the senior lecturers should encourage students to reflect on their cultural influences by avoiding treating any student as ‘representative’ of his or her cultural group as such assumptions may offend some students. The findings also suggested that senior lecturers also need to reflect on their own cultural self awareness, keeping in mind that every individual has their own unique cultural

influences and therefore they need to use educational materials and approaches that do not over-generalise or reinforce stereotypes about particular cultural groups as also demonstrated in other themes already discussed in this chapter.

#### **4.13: Theme 13: Promote open discussions on privileged and marginalised groups when addressing issues of cultural competence**

Another theme that emerged from interviews with senior lecturers and student nurses who participated in this study was the need to **promote open discussions on privileged and marginalized groups when addressing issues of cultural competence** as one of the ways of making students more aware of issues faced by diverse cultures. This was because, as already presented in the findings, many students reported some **dissatisfaction with aspects of how issues of culture are discussed in curricula as they are perceived to promote stereotypes and prejudiced assumptions about certain cultural groups** (Theme 3) and also that some **discussions on cultures bring issues of racism, conflict and controversy** (Theme: 4). As a result, some senior lecturer participants reported cases where students appeared not ready to accept discussions on issues of privileged and marginalized groups such as race and other ethnic oppressions and disadvantages in classroom settings. One senior lecturer made this comment to illustrate the point.

*“Nine out of ten you find that students are sited according to their cultural pockets which makes it harder at times for students to cross share their cultural heritage” [SL8]*

The same senior lecturer participant further went on to say that even where materials are properly and evidentially presented, some students still do not like to accept conversations that focus on issues of privilege and oppressions, as illustrated by the comment below.

*“..... when I brought in and presented some statistics and materials about certain culture you could tell that some students felt as if their cultures are being attacked....” [SL8]*

From the current study findings, there are also reports that White students in classroom settings deny occupying their own privileged roles or more powerful social identities positions, and that it may even take the form of outward anger, resentment, or an overwhelming sense of guilt if such issues are discussed as illustrated by one of the senior lecturer participants comment below.

*“.....at one time I asked students to tick their cultural background in terms of ethnicity and there were some White students who ticked to say that they had no ethnicity or culture” [SL3]*

Some senior lecturer participants in this study felt that one of the ways of approaching cultural competence within the classroom setting and minimizing student group tensions caused by their cultural backgrounds is to openly discuss the privileges enjoyed by being White, no-matter what position and title they may have. One of the senior lecturer had this to say to illustrate the point.

*“..... many text books have for decades now talked about the inequalities in health and the impact such inequalities have on minority patients and I don’t think this could be the solution.....I think educators should start openly and explicitly discuss with their students the advantages that majority White people enjoy in society rather than solely focusing their discussions on the disadvantages faced by minority groups in this country .....” [SL9]*

However, some senior lecturer participants suggested that approaching cultural competence in terms of ethnic minority disadvantage might allow students from the privileged White backgrounds realise the privileged positions they hold over non Whites. The comment below illustrates such a point.

*“.... what is important as a lecturer is to be able to deal with such tensions effectively. One way I will deal with such tensions myself is possibly to approach cultural awareness programs from both the advantages of the privileges enjoyed by White dominant groups and the disadvantages suffered by ethnic minority groups. By so doing, perhaps the privileged dominant members of the group might appreciate other people’s disadvantages and may avoid negative attitudes to them”. [SL3]*

Another senior lecturer participant felt that senior lecturers should approach cultural competence by both discussing the White privileges and ethnic minority disadvantages as way of minimising the racial tensions among the groups of students. The lecturer put the following comment to illustrate the point.

*“.... well, time and again as a mental health lecturer you should expect to find some tensions among diverse groups of students during discussions centered on cultural diversity due to student cultural uniqueness. What is important as a lecturer is to be able to deal with such tensions effectively. One way I will deal with such tensions myself is possibly to approach cultural awareness programs from both the advantages of the privileges enjoyed by White dominant groups and the disadvantages suffered by ethnic minority groups. By so doing, perhaps the privileged dominant members of the group might appreciate other people’s disadvantages and may avoid negative attitudes to them”. [SL3]*

While some senior lecturers in this study felt that approaching cultural competence from the perspective of discussing the White privileges and ethnic minority disadvantages could be one of the best approaches, however, one of the senior lecturers warned about the likely dangers such as



over-generalising or reinforcing stereotypes about particular cultural groups. The comment below illustrates the claim made.

*“.... of course we can try to openly address issues of White privileges and the disadvantages faced by some racial minority groups in this country when teaching cultural competence, however, they are possible dangers that we might over-generalise or reinforce stereotypes about particular cultural groups considering issues of Al-Qaeda and its links to some cultural groups...” [SL4].*

Even some student nurse participants felt that discussing issues of White privileges and ethnic minority disadvantages may bring issues of racism, stereotype and superiority of identity as expressed by the following comments:

*“Some of these people [ethnic minority] it’s not their choice to be here, they were forced... circumstances drove them to loose their identity, let’s not forget the days of slavery, slavery is over and let’s give them the care they deserve.....” [S3FG2]*

*“ .... Before these patients come to Britain, they were at least supposed to think of what could be the consequences when they become ill. Obviously we’re not expected to know their single cultural norms in order to be good nurses. People who want to come to England need to know that they are going to England where English people speak English and nurses are not expected to learn their vernacular languages just for the case of trying to nurse them. .... in my opinion, I think issues of language barriers should not be a burden for the nurses and nursing students, but for the patients’ families... that is if they wish their own relative to be treated by British Nurses ....” [S3FG1]*

*“...if you go to Rome, you are expected to do what in Rome the Romans do, but why is it that that when people come to Britain, they expect the British to be experts in those foreign cultures? ...” [SN7]*

The study findings from this theme seem to suggest the need to promote open discussions on privileged and marginalized groups when addressing issues of cultural competence as one of the ways of making students more aware of issues faced by such groups.

#### 4.15: Study findings: Conclusions

In conclusions, the thirteen themes that emerged in this study can be grouped into three major areas namely:

- a. Background issues or context impacting on cultural competence learning and teaching.
- b. Process of delivery cultural competence specific areas
- c. Programmes of developing cultural competence as well as content.

In particular, the themes that fall into the **background issues or context impacting on cultural competence learning and teaching** are:

- Theme 1: Issues of culture are inadequately incorporated in curricula
- Theme 2: Variation of modules by institutes
- Theme 3: Cultural discussions invite stereotypes, prejudice, discriminations and religious intolerance
- Theme 4: Discussions on cultures bring issues of racism, conflict and controversy
- Theme 5: Education centred on cultures brings boredom in class
- Theme 6: Educator's subject expertise and scarce resources impact on cultural competence education
- Theme 7: Develop educational programs that respond to cultural diversity

Consequently, the themes that fall under the heading **process of delivery cultural competence specific areas** are:

- Theme 8: Incorporate relevant critical reflective educational strategies
- Theme 10: Integrate cultural knowledge into the curriculum as an extensive general framework
- Theme 13: Promote open discussions on privileged and marginalised groups when addressing issues of cultural competence.

Finally the themes that fall under **programmes of developing cultural competence as well as content** are:

- Theme 9: Engagement of multi-professional experts to assist in teaching culturally competence specific areas
- Theme 11: The need for cultural competence education that focuses on effective cultural sensitive skills
- Theme 12: Promote cultural awareness

Although the themes have been grouped into their respective groups, however they are some themes common to more than one group.

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## Chapter 5: Discussion

### 5.0: Discussion: An overview

This chapter discusses the current study findings in terms of how the components of the emergent theoretical constructs relate to the aim of the study and the research question. The research question that guided the current study was: *What constitutes a curriculum to prepare mental health nurses to provide efficient and culturally appropriate care for the diverse populations that they will serve?* The aim of the study was to explore and gain an understanding of cultural competence education from the perspectives of the key participants involved in the undergraduate mental health nursing education within the UK context, and to use the findings to develop a conceptual framework of teaching cultural competence.

Qualitative grounded theory approach was the method of inquiry used to collect and analyse interview data from the experiences and views of senior lecturers, third year mental health student nurses, clinical sign-off mentors and student mentors within the universities that offer pre-registration mental health nurse training in the West Midlands Region. Analysis of the research findings resulted in an emergent conceptual framework that explains how cultural competence is developed in the undergraduate mental health nursing curriculum in terms of content, processes, strategies, actions and approaches that are considered effective. This conceptual framework can be used by health care educators to create a workforce that is capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency.

This chapter begins with a critical discussion of each of the three main theoretical constructs that emerged in this study which are:

- 1. Dissatisfaction with cultural issues in current curricula**
- 2. Conscious of the dynamics and discourse of intercultural education**
- 3. Achieving cultural competence curricula**

Finally, the chapter concludes with the description and an examination of the emergent conceptual framework in its entirety. Although each theoretical construct is presented separately in this chapter, in fact theoretical constructs overlap and interact with one another. The theoretical constructs are presented here as section headings, their associated themes in bold and the repeating ideas are in italic quotes to illustrate the points made.

### 5.1: Dissatisfaction with how aspects of cultural issues are portrayed in current curricula

This study explored cultural competence education from the perspectives of the key participants involved in the undergraduate mental health nursing education within the UK context. As demonstrated by themes 1 to 7 of the findings chapter, study participants expressed their dissatisfaction with how aspects of cultural issues are portrayed in their current curricula. One of the theoretical construct to emerge from those related themes and literature was the **dissatisfaction with cultural issues in current curricula**. This theoretical construct revealed some frustration and disappointment with regard with regard to the current curricula. This is because many study participants felt that **discussions on cultures bring issues of racism, conflict and controversy** (theme 4), **education centred on cultures brings boredom in class as it appears to be irrelevant to the future** (theme5) and that the **inadequate cultural competence teaching resources and educators' lack of knowledge hinder the development of cultural competence education** (theme 6). As a result, majority of the participant in this study felt that cultural competence education is a challenging process as it involves very deeply rooted ideas among students in classroom settings.

For example, the dissatisfactions were evidenced by the fact that majority of student participants in this study reported some occasions when senior lecturers gave *summary statements about the cultural beliefs of certain cultures as if they represent all the cultures [SN2; SN3; SN5]* and also when *some students openly started accusing one another of making some racial comments due to superiorities of their cultures [SN1]*. Furthermore, some students who participated in the study expressed fear that any discussion centred on culture tend to *bring issues of racism, superiority of cultures and controversy among students in class (SL2; S2SFG1; SN1)*. Some student participants felt that the terminologies used by their senior lecturers when teaching them about cultures were too complicated and difficult to comprehend and that their lectures *put more than enough emphasis on the British history and the British values as the best standards which other cultures should follow” [SN5]*. However, other study participants felt that the delivery of cultural competence curriculum *is hindered by the inadequate cultural competence teaching resources and senior lecturers' lack of knowledge about cultural issues that need to be addressed within the curriculum (SL8)*.

However, such dissatisfaction especially influenced by racial and cultural tensions that arose when attempting to address cultural care issues in classroom settings are not new and should not be surprising. Social constructivism (Berger and Luckmann, 1966), hold the belief that participants in the phenomenon are deeply influenced by their diverse life experiences and that learning contexts within the classroom environment (as elsewhere) is socially constructed by the participants. This therefore means that, when learners enter and experience the cultural debates in classroom environment, they enter as a system that is not value free but, they enter this system in an environment where power is exercised that can influence the progress and learning of a student learner (Adams et al., 1997; Kai et al., 1999; Muntaner, 1999; Trentham et al., 2007). This is because learning does not occur in vacuum, but it is a social process of creating knowledge in which the learner brings self, his or her own worldviews including emotion and action into the learning process (Berger and Luckmann, 1966; Brockbank and McGill, 1998). This suggests that in the cultural competence learning process, the learner is supposed to be critical in relation to the domains of knowledge, self, worldviews, action and emotions. If learning embraces and integrates knowledge, self, emotion and action, then teaching and learning cultural competence requires a system of inclusion and integration such as develop educational programs that respond to cultural diversity (theme 7) and , Incorporate relevant critical reflective educational strategies (theme 8) for example.

Further, the literature also suggested that the process of cultural competence education is a gradual process from disagreements to integration of differences that exists (Bennett, 1993) and that people's identities are challenged by other people's ways of doing and thinking and this occurs not always without conflict (Kai et al., 1999; Muntaner, 1999; Trentham et al., 2007). That is possibly why some nursing students may be of the opinion that they *didn't come to university to learn how to provide excellent nursing care to strangers [SN7]* and other students felt that *there cultures are more superior than others.* [SN5]. Nevertheless, Milton Bennett, in his model, *Developmental Model of Intercultural Sensitivity* (Bennett, 1993) provided an outline of the process individuals go through when developing cultural competence using six stages, starting from denial to the integration of cultural differences that exist between people. The stages in Bennett's model may provide a good framework for determining how diverse students may work together and improve the capacity for intercultural sensitivity.

Although study participants reported being dissatisfied with the current curricula, in a positive note, such claims and comments could be considered as critical learning process for the learners which in turn also requires the conditions that enable the learner to “examine and reflect on one’s own cultural background” not only by himself or herself, but with others (learners and senior lecturers). Given the socially constructed nature of knowledge and that the meaning is created in relation to others, then reflection and the creation of meaning is inevitably a social process (Berger and Luckmann, 1966; Brockbank and McGill, 1998). This therefore means that it is possible that what shapes the teaching in the classroom is determined by what is the societal evidence.

For example, the dominant issue especially in UK society now is Moslem and Asians in relation to expression. Most of the focus of training especially by senior lecturers as evidenced from the study findings is on dealing with these issues, other than structured or evidence base materials and teaching approaches. This leads back to the significant relationship in learning where situations are created where senior lecturers and learners together can actively “developing educational programs of cultural competence using educational materials and approaches that respond positively and constructively to cultural diversity”. The substance of the relationship which is created is one of ‘reflective dialogue’ between the senior lecturer and the learners, and among learners. The reflective dialogue relationship is one where the educator and the learners engage and work together so that they jointly construct meaning and knowledge.

The educational materials and approaches and how they are implemented is the product of the relationship and diverse composition between those in the dialogue (cultural backgrounds of senior lecturers and the learners). For example, some of the senior lecturers in this study reported that “*most books are biased on certain cultures and relying on them will be a myth considering acculturation*” [SL4] and also that “*some available text books tend to talk about cultures in general without any clear guidance in relation to mental health nursing*” [SL1]. Senior lecturers’ comments were in complete agreement with student nurse participants who felt that “*... most of the reference materials recommended by their lecturers are biased towards the Western cultures ...*” [SN6]. One learner further went to the extent of mentioning that *majority of the time the books and materials recommended by their lecturers are dominated by information that support the supremacy of the western cultures as number one*” [SN5].

These comments from senior lecturer participants and student nurses are consistent with literature evidence that suggest that the educational material ‘is not out there, detached and unconnected’ as viewed by (Brockbank and McGill, 1998, p. 5). This means that in the condition of reflective dialogue between the educator and the learners, that some materials that could be used could be potential damaging to the dialogue considering the differing worldviews of the participants in the dialogue. This could be true especially if it is also commented by some senior lecturers that “*some available text books tend to talk about cultures in general without any clear guidance in relation to mental health nursing*” [SL1] and that they “*do have some text books stuffed in their libraries but many of them are superficial and lack that detail*” [SL3].

In summary, although the theoretical construct of **dissatisfaction with cultural issues in current curricula** is a very vital one in terms of the state of affair of the current curricula, however it does not wholly directly addresses the study aims or the research question. The construct lays the foundation and the strong rationale for the need of a curriculum that satisfactorily prepares its graduates for work with diverse people. This construct has revealed that in relation to the current curricula, participants within the undergraduate mental health nurse training are dissatisfied and frustrated as already demonstrated by themes 3 to 6. As a result, this construct made a case for the need of a curriculum that provides a framework that provides a basis for educational interventional strategies and approaches capable of minimising the frustrations and disappointments when preparing mental health nurses to provide efficient and culturally appropriate care for the diverse populations that they will serve.



## 5.2: Conscious of the dynamics and discourse of intercultural education

Consciousness of the dynamics and discourse of intercultural education is another theoretical constructs that was labelled from the analysis and syntheses of the related themes and the available literature. This theoretical construct emerged as a result of differing ideological views from study participants about the current curricula in terms of its ability to address issues of cultural competence. In particular, the debates centred on whether the current curricula adequately covers cultural issues, as well as what and how cultural competence should be taught within the curriculum to enable pre-registration mental health nurses to provide services that are culturally appropriate to the populations they will serve.

For instance, from the analysis of the current study findings, there seemed to be two competing groups of educators debating on how cultural competence curricula should look like and how it should be addressed. These two groups of senior lecturers had differing assumptions and ideologies about what and how cultural competence should be taught within the curriculum in order to ‘create a workforce that is capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency’ as suggested by Betancourt and colleagues (Betancourt et al., 2005, p. 499).

Some study participants mostly from the nurse educators felt that **issues of culture are inadequately** or marginally incorporated in curricula as depicted by theme 1 in the results section. This group of participants seemed to support the multiculturalism idea (Banks, 1993), where they felt that they need “*to effectively teach cultural diversity within the current curricula and that as lecturers they also need strong institutional support and some professional development in that particular area of which they claimed that at present it was not to enough*” [SL7].

In contrast, other study participants were of the opinion that **issues of cultural competence have been incorporated across different modules but consistency and quality of training vary from institute to institute** (Theme 2). The participants, especially senior lecturers who assumed

that the cultural competence programs have been incorporated in other modules were adamant about the need to have cultural competence specific modules arguing that *the curriculum is already over stretched and that adding more courses is of no great benefit [SL8]*. This group of participants could be said to supporting and defending the Western dominance idea of culture (Banks, 1993), where they seemed to strongly disagree with the fact that the curriculum does not address cultural competence. This group of participants felt *that there is a lot within the curriculum about non discrimination practice* as suggested by guidance such as *the National Service Framework of Mental Health* and *the NMC Code of Practice* for example [SL4]. In addition, the educators who believe in the Western dominance idea of culture seem to perceive *cultural diversity narrowly as ethnic customs and immigrant religious beliefs [SL8]*. Such perceptions of the Western dominance idea of culture may lead the White British students to believe that cultural competence education is therefore only intended for foreigners and foreign students as illustrated by some of the students' comments who asserted that they *didn't come to the university to learn about providing excellent nursing care to foreigners .....* [SN7] and that they *didn't come to the university to spent majority of our time learning about providing excellent nursing care to foreigners [S6FG2]*. Furthermore, such perceptions may also lead some White British student to view the nursing care needs of people from ethnic minority and foreign backgrounds as deviant and in need of being acculturated to culturally dominant majority White norms as illustrated by some of the students' comments below:

*" .... Obviously we're not expected to know their single cultural norms in order to be good nurses. People who want to come to England need to know that they are going to England where English people speak English ...."* [S3FG1].

*"...if you go to Rome, you are expected to do what in Rome the Romans do, but why is it that that when people come to Britain, they expect the British to be experts in those foreign cultures? ..."* [SN7].

These debates between the participants who supported the Western ideas of culture and the multiculturalists are in nowhere different from the debate witnessed by many scholars and researchers in other Western countries with regard to cultural diversity knowledge that should be taught in the curriculum (Asante and Ravitch, 1991; Banks, 1993; Culley, 1996). However, although there are differing views and perspectives between the two ideological groups, the interesting point is that both the Western traditionalists and the multiculturalists share some common assumptions and beliefs of what needs to be included in the curriculum and how they

preferred issues of cultural competence to be addressed within the curriculum as will be discussed in section 5.3 below. At the same time, both groups openly reflected their values, human interests, ideologies and political position that are consistent with the requirements of a democratic society where the freedom of active citizen participation is encouraged (Banks, 1993; Douglas et al, 2009). This therefore means that the **consciousness of the dynamics and discourse of intercultural education** is both a philosophy and a process.

As a philosophical concept, the debate between the study participants who support the Western traditionalists of cultural competence and those who support the multiculturalists ideological positions is consistent with the ideas of a democratic society that values the principles of democracy, social justice, equity, valuing diversity and the freedom of expression (Rawls, 1971; Banks, 1993; Douglas et al, 2009). The educators who supported the Western ideas content that *“individual lecturer should still have the autonomy on what to include in the curriculum and how they prefer to deliver such teaching” [SL7]* and they acclaim that *“.....if people want to base on statistics, then educators are doing much more in terms of addressing the care needs of foreigners and other non White British people.....” [SL4]*. At the same time, the educators who believed in the multiculturalism ideas felt that they are *all supposed to include it [cultural competence] in most of the topics they deliver as they tend to involve culture [SL6]*.

As a process, from the study findings, **conscious of the dynamics and discourse of intercultural education** is fluid and is continually undergoing modification to meet the needs and demands of an ever-changing UK diverse society. Some senior lecturers who participated in this study reported the impact of culture on mental health and the need to continuously improve the delivery of cultural competence within the curricula. One senior lecturer participant gave this comment to support such idea: *“.....although we are including cultural competence in our current curricula, I think as nurse educators we probably need to do more than what we are doing now .....I strongly believe that integrating cross cultural education into the training of nurses may improve nurse patient interactions among the marginalized patients and there is a lot of research to support me.....” [SL3]*. These senior lecturer participants’ views are consistent with a systematic review of literature by Beach et al. (2005) which found strong support that cultural

competence education enhances the knowledge of health professionals, and that this education assists in changing their attitudes and skills.

Further, such debates between the participants who supported the Western ideology of Western culture dominance and the multiculturalists is also an example of people expressing their freedom in a cultural democratic society such as UK. These debates are also consistent with the published literature by the critical theorists who argue that multicultural education theory ‘creates problems, contradictions, and dilemmas for members of minority groups living in a liberal democracy’ (Rosaldo, 1989, p. 44). The rationale behind such arguments could be because, firstly, liberal democracy is based on principles of liberal theory regarding the importance of respecting individual rights and individual actions, but multicultural education tends to focus on group rights and actions (Rosaldo, 1989). Secondly, critical theorists argue that multicultural education theory directs minority group members into ‘trying to belong to [both] their cultural community and national community (Rosaldo, 1989, p. 44).

Given this critique of traditional Western pedagogy, where only *books and materials that support the dominant cultures are used* [SN5], it is highly evident that a lack of critical inquiry into values informing traditional perspectives has resulted in university practices that prevent student from ethnic minority backgrounds from understanding their world thereby silencing their voices and relegating them to positions of powerlessness in the British mental health educational systems. Hence it is impossible to impact significantly the way cultural competence is addressed within the curriculum without the issue of being **conscious of the dynamics and discourse of intercultural education** in spite of proclaimed democratic ideas.

Additionally, from the study findings, there seemed to be some debate or discourse as to whether training in cultural competence should be provided through separate devoted courses or integrated throughout the curriculum. Additionally, they seemed to be some confusion on how issues of cultural competence could be addressed within the curriculum and what sort of methods and approaches could best be used by nurse educators.

In terms of whether cultural competence should be provided through separate devoted courses or integrated throughout the curriculum, majority of the senior lecturer participants in this study clearly rejected and opposed the need to have cultural competence specific modules arguing that *“the curriculum is already over stretched and that adding more courses are of no great benefit [SL8].* Some senior lecturers who participated in this study felt that cultural competence programmes have been incorporated in other modules and *“that there is a lot within the curriculum about non discrimination practice from the national Service Framework of Mental Health to the NMC code practice...” [SL4],* and that *“ ... issues of cultural nursing care needs have been incorporated into other modules such as Sociology of Health and Illness.....” [SL1].* Other senior lecturer participants argued that although it might be important to have specific modules within the current curriculum on cultural competence, however, they said doing so might be seen by learners as something which should be treated separately and *“students will take that module as an add on extra burden to what they learn, or a separate entity which should be applied separately.....” [SL6].*

These sorts of debates are consistent with reviewed literature where there are also some debates as to whether training in cultural competence should be provided through separate devoted courses (Flores et al., 2000) or integrated throughout the curriculum (Kai et al., 1999). The view points of these lecturers are supported by researchers such as Kai and colleagues who pointed out that placing cultural competence education within separate courses may undermine its importance and force it to become even more marginalised (Kai et al., 1999). Similarly, researcher such as Flores and colleagues argue that the coverage of cultural competence education in one lecture or as an addition to other topics may result in training spread too thinly so that skills are forgotten when a patient encounter occurs (Flores et al, 2000).

Consistent with published literature (Culley, 1996; Wear, 2003), majority of senior lecturer participants in this study claimed to thread cultural content into their existing course content rather than separate course on culture. From the study findings, there is a suggestion as evidenced from interviews and observing curriculum documentation materials used by senior lecturers that senior lecturers integrated cultural issues throughout the curriculum.

By carefully considering the merits of such arguments, suggestions of Kai et al. (1999) may seem to be most productive as these researchers recommend the integration of cultural competence learning throughout the whole curriculum, particularly as discussions focussed on mental health

nursing needs of diverse society are not complete without an acknowledgement of the culturally embedded systems of shared meanings that are attributed to diverse experiences of people. This integration of learning into the whole curriculum according to the study participants can be accomplished in pre-registration mental health nursing educational programs by integrating learning about cultural competence issues through a combination of *inter-group dialogue, reflecting on experiential learning class lectures, use of guest expert speakers on cultural competence, involving community members and case-based scenarios that highlight cultural issues of culturally diverse populations* as discussed in section 5.3 of this study. The integration of cultural competence learning into the whole curriculum is also consistent with the Quality Assurance Agency (QAA) standards which has put forward a statement for the entire health related curriculum including the nursing curriculum to include ‘cultural competence focused education that prepares future mental health nurses to practice in an anti-discriminatory, anti-oppressive manner and to contribute to the promotion of social inclusion’ (QAA 2001, p. 3). Additionally, the threading of cultural competence into the whole course is also consistent with the reviewed literature which discussed the need for nurse educational programmes to include components in which issues of cultural diversity needs are addressed within the entire nurse curriculum (Gerrish and Papadoupoulos, 1999; Kai et al., 1999, Allen, 2010). Through such practices, senior lecturers approached cultural competence as implicit rather than explicit nurse education curriculum.

Furthermore, although the integration of cultural competence education in the entire curriculum is recommended in this study and in literature, however, it should be acknowledged that such integration of cultural competence is not the sole response to cultural competence as cautioned by some researcher (Asante and Ravitch, 1991; Gerrish and Papadoupoulos, 1999). By framing cultural competence issue within what some researchers call a ‘multiculturalist’ perspective (Asante and Ravitch, 1991; Banks, 1993; Culley, 1996), the nurse educators might encounter the risk of emphasising cultural competence training as the sole response to the nursing care needs of diverse populations. This concern is in keeping with Dyck’s (1991) critique of the limitations of cultural competence education approaches, and identifies the need for nurse educators to go beyond the individualistic notion of cultural sensitivity to consider the systemic and structural barriers that impact on the nurse-client dynamic. This could be because an approach solely based on cultural competence education assumes that, with increased knowledge and awareness, the mental health nursing care services of clients from diverse cultural backgrounds will be improved (Asante and Ravitch, 1991; Gerrish and Papadoupoulos, 1999). This would also suggest that

cultural incompetence is then remedied through cultural competence education. Within such assumptions, it could be suggested that solutions facing diverse cultural groups within a diverse society are fundamentally technical and professional rather than political.

In summary, study participants suggested that nurse educators especially senior lecturers must be conscious of the dynamics and discourses of intercultural learning process before designing and implementing cultural competence inclusive curriculum. It was also suggested that the educators must be conscious of how their values, assumptions and ideologies might affect the designing and delivering of cultural issues within the curriculum and that they should demonstrate sensitivity to the dimensions in which differences could exist among themselves and between their diverse student groups in classroom environments. This is because, from the study findings, the process of creating and implementing a curriculum integrated with cultural competence concepts takes time, effort and persistence and that it cannot be achieved without conflict. Finally, in recognition of the legitimacy of those debates and discourses, and with the broad understanding of culture as spheres of shared, learned, transmitted experience and meaning of particular individuals (Leininger and McFarland, 2002), this study proposes the integration of cultural competence training within the entire curriculum.

### 5.3: Achieving cultural competence curricula

Although the study participants demonstrated **differing ideological views about the current curricula** in terms of its cultural inclusiveness (section 5.2) as well as demonstrating their **dissatisfaction with how aspects of cultural issues were portrayed in current curricula** (section 5.1), a further interesting and important theoretical construct to emerge from the related themes and literature was that, both groups of study participants came up with a solution of how they incorporated or preferred issues of culture in the undergraduate mental health nursing curriculum within diverse classroom environments in terms of content strategies, processes, actions and approaches that they considered effective. The subsections that follow discuss such content, strategies, processes, actions and approaches as suggested by study participants from the emerged themes and the reviewed related literature (see Fig. 4). The subsection headings will denote the main constructs of the constituents of cultural competent curricula in terms of content, process and strategies that are considered by study participants and reviewed related literature as important.



### 5.3.1: Developing cultural awareness through self reflection

The development of cultural competence is considered by many cultural competent experts to be a lifelong process or journey during which the individual continually grows in awareness, knowledge and skills (Leninger, 1991; De La Cancela et al., 1998; Campinha-Bacote, 1999; Papadopoulos, 2006). After a careful analysis of the themes in the results chapter of this study and related literature, **developing cultural awareness through self reflection** was considered by both the literature and the study participants as one of the strategies and the departure point in the process or journey of developing cultural competence.

Under this sub theoretical construct, participants in this study felt that cultural competence education demands that both students and senior lecturers know themselves and where they come from, before being able to understand others. Several participants in this study have therefore suggested that when developing and facilitating cultural competence within the mental health nursing curriculum, it is essential for both learners and nurse educators to begin by examining and reflecting on their own cultural backgrounds and biases first, a process commonly known by researchers as “self reflection” (Mezirow, 1997; 2000; Epstein, 1999; Epstein and Hundert, 2002; Boutin-Foster et al, 2008).

It was suggested by the study participants that the departure point for cultural competence education “*is to ask students to consider their own cultural backgrounds and practices before attempting to teach them about other cultures*” [SL3]. By so doing, the senior lecturers felt that the process of “*encouraging the student to reflect on their self*” [SL3] will assist learners to *able to understand and appreciate the cultural differences and similarities that exist within, among and between groups* [SL8]. Other senior lecturer participants suggested that the process will also assist the learners to encounter both the opportunities and the obstacles of this cultural competence education process as *they will be able to understand and appreciate other people’s cultural values and beliefs which are different from them* [SL6]. In particular, educators from the clinical practice and the university based lecturers suggested some of the approaches they employ *to encourage students to reflect and examine their own cultural values and beliefs ..... in order [for the student to be able] to appreciate the cultural values and beliefs of others* [CM1]. Some senior lecturer participants suggested that *some of the mentioned tensions* [among students when cultural issues are addressed in classroom environment] *could be reduced if students are encouraged to*

*express their own individual personal values and beliefs first in order to appreciate other people's values and beliefs [SL7]. Other senior lecturer participants in this study reported that they find it better to start by giving students some work whereby they write about their individual and family cultural values, practices and beliefs before the lesson, then come the lesson, they would ask them to bring their anonymous pieces of work forward so that they can read for the whole class... [SL1].*

Such suggestions from nurse educators in this study are consistent with the literature from many cultural competence experts that emphasizes self-reflection of one's own cultural identity and cultural beliefs as one of the most important facet to developing cultural competence (Marvel et al., 1993; Tervalon and Murray-Garcia, 1998; Campinha-Bacote, 1999; Carrillo et al., 1999; Gerrish and Papadopoulos, 1999; Papadopoulos, 2006). In particular, Gerrish and Papadopoulos (1999) suggested that the starting point of any education programme should therefore be an 'exploration of the students' own cultural values, beliefs, and practices, including their own prejudices' (Gerrish and Papadopoulos, 1999, p. 1434). Papadopoulos (2006) further suggested that by exploring their own cultural beliefs, students would then be in a better position to consider how these may exert an impact upon their interpretation of the values, beliefs and practices of people from other ethnic backgrounds different to their own. Such an approach of allowing students to examine and reflect on their cultural beliefs is also consistent with Betancourt (2003) who states that discussions about the student's own cultural values are important aspects of cultural competence education. In this process of self-reflection, it is commonly believed by nurse educators and from reviewed literature (Mezirow, 1997; Epstein, 1999; Papadopoulos, 2006; Boutin-Foster et al, 2008), that the nursing students will begin to reframe their prior assumptions, take alternative perspectives, and recognize their induced roles and come to understand how their perceptions were formed.

As suggested by some senior lecturer participants in this study and also reviewed literature (Campinha-Bacote, 1999; Lurie and Yergan, 1990), if the diverse student nurses repeatedly interact with one another from different cultural backgrounds, they would have the opportunity to learn and deal adequately with and become comfortable with a variety of cultural issues and scenarios they may encounter both in classroom environment and in practice. This is because, for the nursing students who are beginning to learn to provide culturally competent care to diverse client groups, presenting cultural competence as a developmental process that involves self-reflection and cross-cultural experience may be an important model or framework for learning

(Giger and Davidhizar, 1999; Campinha-Bacote, 2002; Gerrish and Papadopoulos, 1999; Papadopoulos, 2006). . This claim is supported by Tervalon and Murray-Garcia (1998) who described cultural competence as a commitment and active engagement in a lifelong process of self-reflection and self-critique that requires humility. In their studies, as alternative strategies to teaching cultural competence, Tervalon and Murray-Garcia (1998) suggest that when discussing cultural competence, students must also be taught the notion of cultural humility. The same scholars refer to cultural humility as a process of ongoing self-reflection and critique of one's pattern of behaviours (Tervalon and Murray-Garcia, 1998).

The role of self-reflection and critical reflection is also espoused by Epstein (1999) who describes self-knowledge as being essential to the expression of core that could be transferred into other situations and in practice. Through critical reflection, it was suggested by the nurse educator participants in this study that student nurses may come to question some of their prior assumptions about culture and come to understand how their perceptions were formed.

The same approach was described by Boutin-Foster et al. (2008) as transformative learning. According to the transformation theory of adult learning, transformative learning is the process by which one's frame of reference is influenced and altered by cultural assimilations (Mezirow, 1997; 2000; Epstein, 1999). For mental health nursing students, understanding the culture of nursing is important in developing their view of the profession of nursing. This understanding can begin with the processes of self-reflection and critical reflection so that the student nurse is able to re-evaluate past beliefs and experiences of other cultures which had previously been understood within assumptions derived from others. According to the views of the current study participants and the reviewed literature, self-reflection is a course of action by which mental health nursing students begin to reframe prior assumptions, take alternative perspectives, and recognize their induced roles of becoming culturally competent practitioners. Mezirow (2000, p. 8) also cited that transformative learning often involves 'deep, powerful emotions or beliefs' and in this study, this was evidenced when participants reported some **dissatisfaction with how aspects of cultural issues are portrayed in current curricula** (section 5.1).

Therefore, critically examining and reflecting on one's cultural background or simply self reflection is suggested in this study as an initial triumph approach that can help to foster self-awareness to students in the process of developing cultural competence. This suggests that, in the context of cultural competence education, student nurses need to be encouraged to first change their frames of reference by critically reflecting on their assumptions and beliefs and consciously making and implementing plans that bring about new ways of defining their worlds. To do that, senior lecturers in this study suggested that the nursing students need to first appreciate the processes that frame their own attitudes and beliefs by *encouraging students to reflect and examine their own cultural values and beliefs first in order to appreciate the cultural values and beliefs of others [CM1]*.

Conversely, it was also suggested and recommended by some study participants that senior lecturers also need to reflect on their cultural values and practices as well. In other words, study participants claimed that self reflection is not only for students but equally to be done by the educators as well. The study participants asserted that if senior lecturers do not examine and reflect on their own cultural background, they may not be fully aware of the customs and practices of other cultures, such as student diverse cultures in their classes. By not being aware, it was further assumed that those senior lecturers might say or do some things that offend the students and which can hurt the success of the lessons centred on cultural competence. For example, one student nurse participant was upset because the senior lecturer had repeatedly mentioned "*white indigenous population*" as if they're no black indigenous populations [SN5]. Furthermore, another student got very upset because *the senior lecturers mentioned Asians and Moslems when he gave examples of cultures as if they're the only cultures on earth [SN3]*.

Such suggestions of the need for educators to also reflect on their own cultural values are consistent with literature (Kauffmann et al, 1992; Kai *et al.*, 1999; Koskinen et al, 2009). In particular, Kai et al. (1999) support such suggestions and recommendations, adding that educators must also examine their own attitudes and sensitivity towards issues of racism, stereotyping and prejudice. Such suggestions are similar to the recommendations of the American Academy of Paediatrics Committee on Paediatric Workforce (1999) which pointed out that educational programs should include components in which individual providers of cultural competence programs engage in a personal analysis of their own beliefs and values. Similarly, Carrillo et al. (1999) stress the need for understanding the potential biases of the diverse cultures and state that

this realization is critical to negotiations in the cross-cultural interaction. Other previous reports (Kauffmann et al, 1992; Koskinen et al, 2009) show that developing cultural competence within the training process is an extensive, intensive, and long-lasting process that requires personal investment from the student, support from educators, and favourable classroom environment. Furthermore, cultural competence models and frameworks that cite self-reflection as a key element of cultural competence education approaches and strategies mention the importance of exploring one's own cultural and family values and influences (Leininger, 1999; Campinha-Bacote, 1999) and exploring one's own biases or prejudices (Campinha-Bacote, 1999; Carrillo et al., 1999).

Additionally, it was suggested by Nieto and Bode (2008) that due to lack of cultural awareness, many educators fail to appreciate real similarities and differences between their understanding of their own "world" and that of their diverse students. Therefore, it could be one of the reasons why self awareness is considered by scholars such as O'Hagan as 'the most important component in the knowledge base of culturally competent practice' (O'Hagan, 2001, p. 235). As considered by study participants and literature, **developing cultural awareness through self reflection** is suggested in this study as the major strategy, an approach and the departure point in the process or journey of developing cultural competence within the undergraduate mental health nursing curriculum.

### 5.3.2: Integrating cultural knowledge into the curriculum as an extensive general framework

**Integrating cultural knowledge into the curriculum as an extensive general framework** has been labelled as another important sub theoretical construct in developing cultural competence within the mental health nursing curricula. The theoretical constructs of **integrating cultural knowledge into the curriculum as an extensive general framework** revealed a range of views on the cultural competence education experience, its contribution to the competence of student nurses, and on how it could be improved. For most study participants, the current curriculum was not considered to have adequately addressed the issues of culture and its influence in the practice of mental health nurses and did not appear to cover cultural competence in the level of detail that is evident in the literature as demonstrated by theme 1 of the results chapter. Study participants asserted *that issues of culture were marginally incorporated in the curriculum to cover the legal and professional requirements [SN7]*. Some student nurse participants claimed that *the issues of culture were covered a lot throughout the undergraduate nursing curriculum but, not in a meaningful depth to distinguish stages of progression [SN3]*. They further claimed that *learning the same issues every time throughout the three years becomes boring and is not helpful [S1FG2]*. As a result, study participants expressed the need for reflective space to consider cultural issues in more details and to have access to *cultural competent experts such as community leaders and ex-service users to come as visiting lecturers [SN5; SN7]*. Consequently, one of the major aspects of preparing students for work with diverse patients suggested by many study participants was *the need for comprehensive cultural knowledge to be integrated into the mental health nursing curriculum [SN5]* as a number of them felt that it was inadequately being integrated and therefore not covering some of legal frameworks such as the National Institute for Mental Health in England (1999). Further, the participants suggested that *the curriculum materials, textbooks and other resources used in classrooms should clearly produce meaning and define what is appropriate in promoting social relations among diverse student groups*” [SL7]. This was after some student nurse participants in this study had reported some concerns about educational materials which they suggested as not being cultural sensitive claiming that *“majority of the time the books and materials recommended by their senior lecturers are dominated by information that support the supremacy of the Western cultures” [SN5]*.

Additional, some of the comments from student nurse participants in this study suggested that some of the examples of certain cultural groups used in classroom environments could be considered as cultural stereotypes (Ciesielka et al, 2005). One of the cited examples was a scenario of *an Asian woman who was suffering from depression following the death of her family members in a temple fire [SN3]*, which could potentially create a specific image about people from this culture. These findings suggest that undergraduate nursing programmes ‘may fail to prepare nurses with the skills to provide care that incorporates and reflects the patient as a culturally situated individual’ (Kennedy et al, 2008, p. 364).

Such comments are consistent with evidence gathered in Anyon (1980)’s content analysis studies which concluded that some of the books and materials used in educational settings are dominated by themes that support dominant cultures. Anyon (1980) further argued that such books used in classroom environments rarely said about social struggle or class conflict, but have a number of myths regarding the nature of political, economic and social life. Such findings suggest that although issues were observed more than two decades ago, nothing has really changed.

Whilst explicit references to such frameworks did not emerge from the data, the views and practices described by student nurse participants were consistent with the National Institute for Mental Health in England values related to the development of a mental health work force that is capable of delivering effective mental health services to a multicultural population (NIMHE, 2003).

Though the participants in this study suggested the integration of cultural knowledge into the curriculum as a very important aspect of preparing students for work with diverse clients, however, they also realized that although the knowledge aspect should be comprehensive, it cannot possibly be all-inclusive given the constraints of time and the magnitude of the task.

The study participants recognised that the purpose of comprehensive cultural knowledge in the curriculum is not *an intensive study of every cultural group that can be found on earth or in the United Kingdom*, but, rather, an extensive, general framework from which the future nursing graduates, as they continually develop their professionalism, *which student s can build upon [CM2]* and can continue to develop in cultural competence. Study participants asserted that through the integration of cultural knowledge in the curriculum, the approach *provides insights into cultural diversity as a stepping stone towards cultural competence.... [SL3]*. In other words the integration of cultural knowledge into the curriculum is believed to lay down the foundation

for cultural competence as well as developing cultural awareness for nursing students. The study participants, especially senior lecturers further furnish that intercultural knowledge erodes ethnocentric perspectives, whereby primacy is given to the majority white population and only peripheral recognition is given to the presence of other Black and ethnic groups (The Sainsbury Centre for Mental Health, 2002; Sue, 2004) as well as highlighting and validating cultural diversity of people.

To attempt to proactively build a knowledge base around a particular ethnic group was considered unnecessary and prior generalised knowledge was thought to increase the likelihood of stereotyping and making false assumptions about an individual as illustrated by one of the student's comment below. "*....people are unique, cultures are also unique hence teaching us about specific cultures in this country will only make us generalize people and stereotype them...* [S2FG1].

An alternative position offered by some study participants was that the lack of background knowledge was a barrier to understanding the individual, and that *balancing between generic and specific cultural knowledge* as well as the knowledge and awareness of the traditions, beliefs, values, and family dynamics of a cultural group may help to contextualise the experiences of a client and facilitated shared understanding. This position is more consistent with the literature on cultural competence within the UK context (Papadopoulos, 2006).

In addition, study participants suggested that the nursing students need to be equipped with the knowledge of the diverse people's contribution to the society. In particular, one of the study participants asserted that *nursing students need knowledge on how diverse people built, shaped, defended, and helped our nation from the times of the wars, after the world war 11 and to present* [CM2]. Another senior lecturer participant also commented that in order "*..... to minimize this perspective where some students feel threatened socially, economically and politically by the presence of ethnic minority people, they often suggest to students to present some broad information of the contributions to British history of the many people who comprise the UK ...*" [SL9]. According to some of the study participants' views, an educational focus on the knowledge of the diverse people's contribution to the society provides future nursing graduates with different ways of looking at facts and deriving solutions. Furthermore, the study findings seem to suggest that if the nursing students understand that there are many ways of looking at and thinking about



their world, it will help them to realize the contributions brought into their society by diverse people and that no one cultural perspective is the best. For example, one cultural group may contribute with *curry dishes which will be enjoyed by most indigenous people* [CMS1].

In addition, an integrated cultural knowledge within the curriculum such as an exploration of the cultural underpinnings in people's attitudes towards ethnic groups, according to study participants, may *develop greater sensitivity and understanding of cross-cultural behaviours and attitudes* [SL5]. It may also *encourage future nursing graduates to examine their own feelings, attitudes and beliefs about these important issues* [SL3]. These findings are consistent with reviewed literature which suggests that 'cultural knowledge is required in order to understand the similarities and differences of cultural groups as well as the inequalities in health within and between groups' (Papadopoulos et al., 2004, p. 109).

One of the identified strategies by participants in this current study of how the curricula could be improved to prepare cultural competent practitioners is by **developing and balancing culture specific and generic cultural competence training**. Culture-specific competence training according to the current study participants and reviewed literature refers to the training of student nurses that focuses on the knowledge and skills that relate to particular ethnic group in terms of enabling pre-registration mental health student nurses to understand the values and cultural prescriptions operating within the particular cultural groups (Gerrish and Papadopoulos, 1999; Gerrish et al., 1996). Generic cultural competence training according to current study participants and literature refers to the acquisition of knowledge and skills that are applicable across different ethnic and cultural groups such as general communication skills and understanding of legislation and policies in order to address issues of racism, stereotype and prejudice (Gerrish and Papadopoulos, 1999).

The culture specific competence training is believed by some study participants as an approach that enhances cultural competence by teaching pre-registration mental health nurses cultural information about *major specific cultures that are mostly found on the placement settings such as Moslems, Afro Caribbean, and Sikhs and so on....*" [CM1]. In terms of developing culture-specific competence training within the curricula, one of the suggested ways of helping students was through the *case scenarios which the senior lecturers found to be useful when it comes to transfer theory into practice* [SL5]. It was suggested by the study participants that students can be provided with the opportunity and exposure to conduct some *case studies of a culture different*

*from them to find more about their history, origin, faith, religion, values, food, dressing, rituals and so on..... [SL1].* It is also believed by some study participants and reviewed literature that such an approach will enable students to develop generic cultural competence as they will be able to generalise certain shared cultural values within certain cultural groups (Gerrish and Papadopoulos, 1999). In addition, a number of student nurse participants and some clinical mentors in this study supported the culture specific competence training approach, suggesting that it has some practical applications and therefore if educators were giving students more information about specific cultures of the local populations, student would benefit a lot. The comments below elaborate such suggestions:

*“.....I know it’s difficult for lecturers to teach us about the care needs of everyone, however, they must teach us about the basic cultural needs of the major cultural groups around us.....” [SN2].*

*“ ..... of course the world has probably millions of cultures, but why not teaches us about those common ones....” [S5FG2].*

*“I think I would teach learners about the major specific cultures that are mostly found on the placement settings such as Moslems, Afro Caribbean, and Sikhs and so on....” [CM1].*

Although culture specific competence training has practical applications as suggested by some study participants, a solely culture-specific centred approach was fiercely rejected by some senior lecturers in this study arguing that giving information on specific cultures when addressing the care needs of diverse cultures, would *promote stereotypical views [SL2]* on the students which might make students think that *cultures are homogeneous and discrete [SL4]*.

Although the study findings suggest that senior lectures could select the attributes of a particular culture when teaching cross cultural nursing care using case studies, however, Carrilo et al. (1999) warned about the inherent risk of generalizing the attributes of a particular cultural group to everyone who shares aspects of that culture. The authors argued that increased globalization has made it less likely that in any one cultural group that could be found would have all of the individuals within that group sharing the same beliefs and attitudes (Carrilo et al., 1999). For example, one might be from a Moslem background, but might not believe in Haalal meat or one might come from an Afro Caribbean background and not religious. Furthermore, reviewed

literature such as Barnard (2007) pointed out that ‘as the country becomes more cultural diverse, more different cultures come into contact with one another and influence each other leading to dramatic changes that reformulate the original culture and identity, a process usually known as acculturation’ (p. 32). Additionally, another challenge could be that an individual client may be acculturated and consciously reject the cultural practices of his cultural group or, that individual client may be immersed in his traditions and accept only the values of his own cultural group. It is therefore important for nurses and other health care practitioners to gain knowledge about diverse cultures and the degree of acculturation of the individuals if nurses are to provide cultural competent care to their diverse clients (Kirmayer, 2002; Campinha-Bacote, 1999).

Basing on Carrilo et al. (1999) and Barnard (2007)’s lines of reasoning, there is a suggestion that cultures are not static traits that can be committed to memory and applied categorically. Rather, such comments complements the notion that cultures are constantly changing according to various factors such as social, environmental, political, legal and so on (Fuller, 2002; Betancourt, 2003; Wear, 2003; Boutin-Foster et al, 2008). This therefore suggest that when senior lecturers teach student nurses about cultures, they must try to broaden the concept of culture by balancing culture specific and generic cultural competence training basing on the social, economic, political and environmental factors that are at play.

Senior lecturer’s perspectives and comments in this study are consistent with the critics (Carrilo et al., 1999; Stables, 2005) who argue that the increased knowledge of particular cultural groups might, in fact, enhance the feeling of difference among diverse student groups and may not necessarily lead to critical examination of the dominant culture. These critics further went on to say that focussing on particular groups when addressing cultural competence within the classroom environment does not encourage dialogue among groups of students about how to work through differences (Carrilo et al., 1999; Stables 2005). Their findings suggest that treating cultures as discrete units strengthens the boundaries between majority and minority cultures (Carrilo et al., 1999; Stables 2005).

In conclusion, a sound initial approach to mental health nursing students with integrated cultural knowledge within the curriculum lays a foundation of cultural competence. This is because as

suggested by Brennan and Cotter (2008), ‘cultural competence can be increased by including structured cultural knowledge content in nursing curricula and multicultural learning experiences’ (Brennan and Cotter, 2008, p. 156). Given the global view of cultural competence education, therefore, future nursing practitioners can clarify and develop their own perspective of cultural competence in order to provide efficient and appropriate care to people from different cultural backgrounds.

It was suggested from the study data and related literature review that integrated cultural knowledge frames learning, thinking, and behaviour within a cultural context and invites undergraduate mental health nursing students to become aware of their own cultural perspectives (Papadopoulos, 2004; Sue, 2004; Brennan and Cotter, 2008). In short, an initial approach to students with an integrated cultural knowledge within the curriculum as a general framework through ‘cultural responsive education’ encourages the life-long process of developing the necessary cultural competence for bridging the gap between the students from majority culture and nursing students from ethnic minority cultures.

For the purpose of this discussion, “*cultural responsive education*” has been used here to refer to the institutionally supported commitment type of learning and teaching that values individual background, contribution and recognizes individual student learning styles using educational approaches, methods and materials that are effective and responsive to the cultural diversity of learners. It is also an educational approach that focuses on providing students with the continuous skills, attitudes and knowledge of challenging any forms of discriminations and prejudices while promoting individual cultural values, beliefs and practices.

### 5.3.4: Incorporating activities that encourage cultural sensitive skills

Incorporating activities that encourage cultural sensitive skills within the curriculum is another sub theoretical construct that emerged as an important theme in the development of cultural competence within the undergraduate nursing curriculum. Study participants suggested that a cultural competent inclusive curriculum should address relevant cultural sensitive skills. As a result, the study participants suggested that that one of the ways of building student nurses' cultural sensitive skills is through subjecting them to intercultural experiences during their university based learning activities and clinical placement activities. For example, cultural sensitive skills that were identified by study participants and the reviewed literature as relevant include effective communication strategy, client centred approach, use of interpreters, building a therapeutic relationship with clients, reaching a shared understanding between staff and clients, addressing issues of holistic patient centred approach and subjecting nursing students to intercultural experiences in appropriate clinical settings.

The study participants expressed a need for pre-registration mental health nurse training curriculum to put more emphasis on the communication and language needs of diverse cultural groups within the society, with many of the participants stating they would like the opportunity to undertake education and training that focuses specifically on *effective communication strategies and language needs (SN7)*. In particular one of the student nurse participant commented that *communication is one of the important care needs of patients from different cultural backgrounds and that nursing students would like more of those sessions [SN2]*.

In addition to effective communication strategies, some clinical nurse educator participants stated that they *have come across many of their nursing students who were very good communicators but when it comes to work with clients, they could not develop proper rapport with clients* and as a result suggested building a good rapport with clients as one of the cultural sensitive skills which needs to be further *addressed within the classroom setting by their lecturers [CM1]*.

In clinical placements where students are taught and assessed for their practical skills, some clinical nurse educators in this study reported that some *finally year student nurses lack the negotiation skills when it comes to care planning [CSM1]*. As a result, some participants felt that *mental health nurses need to be trained on how to negotiate with the clients during care planning,*

*implementation and reviewing [CM2]. Senior lecturer participants also stressed the need of negotiation skills when discussing any treatment plans with the clients and then negotiate the plans of care with clients and their families or carers” [SL8]. Therefore, negotiation skills are also important cultural sensitive skills that need addressing within the curriculum according to study participants.*

Related to effective communication strategies, interviewing skills were also considered by some study participants as vital cultural sensitive skills that needs to be addressed within the curriculum. For instance, some student nurse participants felt that *some cultures, if interrupted when they are talking during interviewing them, they become upset or aggressive, therefore practitioners need the interviewing skills of listening to them attentively” [S3FG2].*

Holistic patient centered approach when addressing cultural competence within the curricula was identified by both literature and study participants as another crucial cultural sensitive skill that need addressing when developing cultural competence. In addressing holistic patient centred approach, the study participants suggested that student nurses should be encouraged to give more focus on the patient and their family as they are in a much better position to identify and understand their needs. In particular, it was suggested that *when planning and implementing any nursing interventions, students are supposed to know that the centre of the focus is the patient and their immediate family (CSM2). The rationale given was that the patient and their family were considered to be in a better position to identify and understand their cultural beliefs and influences that affect their mental health and recovery (CSM2).*

The study participants also suggested that the nursing students *need to be exposed into the clinical settings where they get the opportunity to work with people from all backgrounds which includes the dominant and the minorities backgrounds [SL3].* The rationale for subjecting them to appropriate clinical placements was that direct and meaningful experiences with people from diverse backgrounds, including those from black and other minority backgrounds will help them understand diverse people’s care needs. The educator participants especially from the clinical side recommended nursing students to be allocated clinical placements that subject them to personal experiences with patients from diverse cultural backgrounds in order to better understand their own cultural identity through comparison and contrasting with other cultural groups. They asserted that *direct and meaningful experiences of students with clients from different cultural backgrounds will help them understand diverse health care needs of people [CM1].* Other clinical

tutor participants in this study commented that they *encourage and give students the opportunity to work with named clients so that they build a therapeutic relationship by sharing some personal information with that particular client* in order to *facilitate some trust* [CM2]. Study participants further asserted that those intercultural experiences gained in clinical placements can help to *reduce the anxiety experienced by nursing students in unfamiliar cross cultural encounters* and thereby *boosting their self-confidence when interacting with clients from different cultural backgrounds* (CM1). Such findings are consistent with literature that suggest that cultural sensitivity immersions may reduce or avoid ‘insensitivity’ and may help to ‘establish trust and rapport in order to facilitate accurate assessment, diagnosis and the delivery of holistic culturally appropriate care (Papadopoulos et al., 2004, p. 113).

In summary, when developing cultural competence within the curriculum, study participants and the reviewed literature recommended the incorporation of the activities that encourage cultural sensitive skills within the undergraduate mental health nursing curriculum. The activities that were considered to promote cultural sensitive skills by the study participants and the reviewed literature includes but not limited to effective communication skills, interpersonal skills, use of interpreters, relationship building skills, issues of holistic patient centred approach, establishing good rapport and trust with clients, good negotiation skills, challenging and dealing with any forms of discriminations and prejudice, as well as subjecting nursing students to intercultural experiences in appropriate clinical settings. As already discussed elsewhere in this study, educators and curriculum developers should be conscious of the dynamics and discourse of intercultural education before and during the incorporation of such activities.

#### 5.3.4: Engagement of local experts to assist in teaching cultural competence specific areas

Another strategy as well as an approach that was employed by study participants when educating student nurses in ways that will enable them to become cultural competent was the engagement of local population, service users and experts on cultural competence to assist in teaching culturally competence specific areas (theme 9).

According to the views of the study participants, *there is no better way to develop understanding of a culture than to live within it [SL3]*. A number of participants in this study both from educators and student nurses emphasised the importance of engaging local community members, service users and cultural competence experts when addressing issues of cultural competence within the pre-registration mental health nursing curriculum. Some participants in this study felt that *“having a community member and or the mental health service user, working and interacting with the students as part of the guest lecturer provides nursing students with an increased opportunity to learn more about the cultural nursing care needs of those represented.” [CSM2]*.

Furthermore, when addressing programs or aspects of cultural competence programs within the curriculum, some senior lecturers in the study were beginning to make use of community members, service users and cultural competence experts as essentially team members in designing and implementing plans for the cultural competence curriculum that addresses the nursing care needs of the members of the communities that nursing students will serve. According to the views of participants, some of the community members and service users involved are also *responsible for identifying and providing support for lecturers when addressing issues of cultural competence within the curriculum [SL9]*. The success of engaging local population, service users and experts on cultural competence to assist in teaching culturally competence specific areas according to one senior lecturer participant is based on an underlying belief that *community members and service users are not the source of cultural competence knowledge and skills, but, rather, are partners in planning for their communities’ general needs. [SL9]*.

These findings are consistent with wider literature and several studies which continue to point to community member, service user and cultural competence expert involvement in the nurse curriculum as a major factor in improving student triumph towards cultural competence (Department of Health, 1994b; ENB, 1996; Forrest et al., 2000; Livingston and Cooper, 2004; Anderson et al., 2007). Many participants especially student nurses in this study reported to have



*learnt much about being culturally sensitive when interacting with community members who were involved in the delivery of the curriculum [SN1]. Other participants in this study reported to have learnt and gained as much as possible about some of the community members' culture from the ex service users who participated in some of the lectures [SN3] including how different cultures within the communities view mental health issues [SL5].* Such approaches are again consistent with some research studies which suggest that service users and community members' involvement in training are becoming active educators in professional training that benefit both the teachers and those taught (Forrest et al., 2000; Department of Health, 1999; 2001; Happell et al., 2002; Livingstone and Cooper, 2004; Anderson et al., 2007). In addition, studies from Pacquiao (2008) reported that clinical encounters with diverse populations are found to be significant in developing cultural proficiency and effectiveness for learners.

In this study, it was also evident that some participants from among the student nurses, clinical mentors and sign-off mentors felt that by involving the community members and service users in the delivery of teaching, the curriculum would at least focus on the cultural care needs of the local population. However, majority of the senior lecturer participants were very clear on what not to be taught in order to avoid 'homogeneous cultural assumptions' (Carrillo et al., 1999) of thinking that all members of a particular culture represented by a community member share the same cultural attributes.

Some senior lecturers in this study admitted that focussing on specific cultures when involving community members and service users in nurse education and doing case studies may have some benefits to students when addressing issues of cultural competence. For example, one senior lecturer gave this comment:

*"In Birmingham we have got a lot of people from cultural different backgrounds. I sometimes ask my students to do case studies of a culture different from them to find more about their history, origin, faith, religion, values, food, dressing, rituals and so on..... I then ask students to come and present their findings to other students for example if one picks a Moslem culture, I would expect them to say in terms of food, Moslems would only eat Halal meat..... by so doing, the student would at least have some ideas that when they serve food to Moslems, they need to be cultural sensitive to the meat they give them....."* [SL1]

Therefore, it could be concluded that having a community member and or the mental health service user, working and interacting with the students as part of the guest lecturer provides

nursing students with an increased opportunity to learn more about the care needs of those represented as well as benefiting the educators and those being educated. Therefore, **engagement of local experts to assist in teaching cultural competence specific areas** was considered by both study participants and the reviewed literature as one of the major strategies that needs to be incorporated when developing cultural competence.

### 5.3.5: Creating educational activities that challenge stereotypes, prejudices, discriminations and religious intolerances

Although the study findings identified that there were some examples of good practice in the delivery of cultural competence curricula, however, the study findings revealed that there are many educational programmes that fell short in terms of challenging stereotypes, discriminations, prejudices and religious intolerances encountered in classroom settings and in clinical practice. This has partly been attributed to the fact that majority of the time in classroom environments, *nursing students are seated according to their cultural pockets which makes it harder at times for students to cross share their cultural heritage [SL8]*. Some of the reasons for such attributes were related to little emphasis being placed on privileges' afforded to those who are White and the disadvantages suffered by those who are non White. It is also claimed that even where materials are properly and evidentially presented, some students still do not like to accept conversations that focus on issues of privilege and oppressions because *some students felt as if their cultures were being attacked.... [SL8]*.

As a result, some senior lecturer participants felt the need to promote open discussions on privileged and marginalised groups in society as one of the approaches to developing cultural competence. Some senior lecturers in this study felt that one of the ways of approaching cultural competence within the classroom setting and minimizing student group tensions caused by their cultural backgrounds is to openly discuss the privileges enjoyed by being White, no-matter what position and title they may have. Other senior lecturers are suggesting to starting openly and explicitly discussing *with their students the advantages that majority White people enjoy in society rather than solely focusing their discussions on the disadvantages faced by minority groups in the country ..... [SL9]*. By so doing, it is believed that *perhaps the privileged dominant members of the group might appreciate other people's disadvantages and may avoid negative attitudes towards them [SL3]*. This can also be transferred to the clinical settings.

While some senior lecturer participants felt that approaching cultural competence from the perspective of discussing the White privileges and ethnic minority disadvantages could be one of the best approaches, however, other senior lecturer participants warned about the likely *possible dangers such as over-generalising or reinforcing stereotypes about particular cultural groups considering issues of Al-Qaeda and its links to some cultural groups [SL4]*.

In addition, it was reported that some senior lecturers felt *ill equipped to teach cultural sensitive topics and issues related to anti discriminatory practice in mental health [SL9]*. As a result, it is suggested that they “*lacked the understanding of the implications of cultural diversity in practice [CSM2]*” and “*felt ill equipped to challenge the expression of racist sentiments in practice settings [CM2]*”. Such findings are consistent with the recent findings of Hildenberg and Schlickau (2002, p. 240, which said that many nurses lack the skills and knowledge that are necessary to successfully provide culturally competent care to culturally diverse populations and to challenge any discrimination suffered by the clients (Narayanasamy, 2003; Serrant-Green, 2001). The challenge of promoting open discussions on privileged and marginalised groups when addressing issues of cultural competence is therefore a necessary and timely consideration. This could be because, related to discussions focused on race-based analysis is the emerging field of studies of Whiteness (Giroux, 1997; Jackson, 1999; Puzan, 2003; Sue, 2004). This field of Whiteness argues for a better understanding of what it means to be White in the Western society (Giroux, 1997; Puzan, 2003). This argument is based on the assumption that in order to acknowledge and understand discrimination, there must also be recognition of the privileges afforded to those who are White and the disadvantages suffered by those who are non White (Giroux, 1997; Jackson, 1999; Sue, 2004). However, addressing privileges afforded because of being White or simply teaching whiteness some will argue that it promotes a Western individualistic Eurocentric bias, and as Masud (2007) has suggested, could result in the privileging of a particular Western version or idea of mental health. It could equally be argued that the strategy encourages and prepares future practitioners to be able to challenge any forms of discriminations and prejudices both in classroom environments and in clinical settings when developing cultural competence and when implementing culturally competent care in practice respectively.

Therefore, it is vital to promote open discussions on privileged and marginalized groups when addressing issues of cultural competence as one of the strategies making students more aware of issues faced by such groups in order to prepare them to challenge any forms of discriminations and prejudices that such groups may face. By so doing, they will be practising care in a competent manner.

Additionally, study findings suggested that when issues of cultural competence were being addressed in classroom settings, majority of the times conflicts among students do arise which hinder the smooth flow of the learning process. The researcher attempted to explore from both

study participants on what could be causing those conflicts. Several study participants felt that those conflicts were triggered by issues such as inadequate cultural competence teaching resources and educators' lack of knowledge. Others felt that the current educational programs of cultural competence do not use educational materials and approaches that respond positively and constructively to cultural diversity. Some participants complained that education centred on cultures brings boredom in class as it appears to be irrelevant to the future, while others felt that discussions on cultures bring issues of racism, conflict and controversy as they are perceived to promote stereotypes and prejudiced assumptions about certain cultural groups.

The study participants' responses on what could be causing those group conflicts such as stereotypes, prejudice, discriminations and religious intolerance when issues of culture were addressed in classrooms settings were no different from what the sociological theories suggest. As originated with the work of Karl Marx in the mid-1800s, conflict theory suggests that human behavior in social contexts results from conflicts between competing groups over scarce or limited resources (Pratto, 1999). As a result, subsequent thinkers have described different versions of what could be causing such group conflicts as well as suggesting how such conflicts could be minimised (Tajfel and Turner, 1986; Sidanius, and Pratto, 1999; McLeod, 2008). In particular, the "realistic group conflict theory" states that groups competing for dominance develop critical attitudes that explain their ill feelings toward each other (Esses et al, 1998; Whitley and Kite, 2010). As stated by Sherif who is one of the founders of "realistic group conflict theory", in one his most famous experiments, "The Robber's Cave", argued that the conflict between groups occurs when two groups are in competition for limited resources (Sherif et al, 1961; McLeod, 2008). The theory further states that the competition between groups for desired scarce resources leads to intergroup stereotypes, antagonism, negative prejudices and group conflict (McLeod, 2008). This could be because such competition creates incompatible goals for members of different groups as one group's success in obtaining those resources prevents the other group from obtaining them. Such conflicts of interest may lead to hostility between groups during discussions centred on culture as reported by study participants.

The events at "Robbers Cave" (Sherif et al, 1961) mimicked the kinds of conflict that plagued the groups of nursing student participants in the current study. From the study findings, it could be suggested that the conflict in classroom settings among groups of students from different minority backgrounds existed because of competition, possibly in terms of superiority of ideologies, cultural values and values between groups.

There is a lot of evidence to suggest that when people compete for scarce resources such as jobs, superiority of cultural and religious values etc, there is a rise in hostility between groups. For instance, in times of high unemployment there may be high levels of racism among white people who might believe that people from black and ethnic minority backgrounds such as the asylum seekers may have taken their jobs and state benefits. This could be one of the explanations of why many people of Asian descent especially from Muslim religion are suffering a backlash and are perceived to be discriminated after the terrorist attack on the Woolwich murder in London on 22 May 2013.

With the intention of having a deeper understanding the psychological basis of intergroup conflict which was reported in the current study by study participants, the researcher explored further on the social identity theories (Ellemers, 1999; Hogg and Vaughan, 2002). Social Identity Theory as developed by Tajfel and Turner in 1979 asserts that group membership creates ingroup or self-categorization and enhancement in ways that favor the in-group at the expense of the out-group (Tajfel and Turner, 1986; Haslam, 2001). The examples of Turner and Tajfel (1986) showed that the mere act of individuals categorizing themselves as group members was sufficient to lead them to display ingroup favoritism. This may be based on individual group member's desire to think highly of his or her group playing up its qualities and denigrating the attributes of those outside it. The significance of the social identity model (Tajfel and Turner, 1986) in this study is that it integrates what is known in social psychology about social cognition, self-conception, and group as well as intergroup processes. Linking the events in the study to the Social identity theory (Tajfel and Turner, 1986), it could be suggested that, when diverse nursing students were acting in groups in classroom settings, they defined themselves in terms of their group membership and seek to have their group valued positively relative to other groups. So if they defined themselves in terms of their White British nationality, they expected their cultural values to be superior compared to others and they expected those values to be taught as the standard. This meant that students from Black and ethnic minority backgrounds were found in groups that were devalued compared to White British students.

Based on the realistic group conflict theory assumptions, several conclusions could formulated in relation to how issues of cultural competence could be addressed within the curriculum in the most tolerant way. From the current study findings, it was determined that because the groups of diverse nursing students were coming from many different racial, cultural and ethnic

backgrounds, therefore individual differences were not necessary or responsible for intergroup conflict that were reported to have occurred. As reported in this study, when the indigenous White British students and students from other ethnic minority backgrounds were competing for superiority of cultural values that needed to be given more attention within the curriculum, it was noted that hostile and aggressive attitudes towards each group arose. This was evidenced for instance, where it is perceived that precious time is going to be spent addressing the care needs of the foreigners. In other words, there was a conflict of interest between ethnic groups of students which arose from competition over scarce resources and values. This conflict of interest acted as a catalyst to antagonistic intergroup attitudes and conflict.

Just as the realistic group conflict theory argues that competition for desired but limited resources creates intergroup conflict, it also argues that cooperation in pursuit of super ordinate goals, mutually desired outcomes that are unobtainable without such cooperation, has the potential over time to reduce intergroup conflict and to create positive relations among members of cooperating groups (Tajfel and Turner, 1986; Haslam, 2001; McLeod, 2008).

Therefore, it could also be argued that promoting learning that involves diverse student groups is insufficient, by itself, to reduce negative attitudes among nursing students. However, it could be concluded that the reported friction between diverse groups of nursing students can be reduced along with positive intergroup relations maintained, only in the presence of common goals that promotes united, cooperative action. This might involve the involvement of both groups to have some open discussions of the privileged and disadvantaged people in society. For instance, if the two groups are interdependent, then the intergroup attitudes will be positive, with little in-group bias or out-group rejection.

One of the questions that the researcher of this study raised was about the strategies that could be taken to integrate the value of tolerance in the curriculum. In particular, the researcher asked nurse educator participants about: *What strategies can they take to integrate the value of tolerance in the curriculum?* As a prompt and follow up question, the researcher also asked about: *How else can they challenge prejudice and discrimination among their groups of students?* [see appendices 1 and 3]. Majority of the nurse educator study participants strongly believed that if they create educational activities that challenge stereotype, prejudice, discrimination and religious intolerance

effectively, they can prepare future nurses who prevent future abuses, as well as empowering some of the most disadvantaged people in society to realize their rights.

The study findings suggested a number of ideas and strategies that could be used within the mental health nursing education setting to challenging stereotypes, prejudice, discrimination and religious intolerance wherever these are encountered. Some of the suggested ideas and strategies included but not limited to common values formation, exposure clinical placements to “marginalized” groups, involving religious leaders as visiting lecturers, promoting open inter-ethnic dialogue, self-awareness, adhering to anti-discrimination policies, as well as understanding that all forms of prejudice and discrimination must be challenged at every level of learning and practice. In addition, study participant lobbied for open discussions on privileged and marginalised groups when addressing issues of cultural competence. Additionally, study participants suggested the provision of a stimulating educational activities that challenge negative attitudes towards some ethnic, racial, cultural and religious groups as well as immigrants, and looks at Britain's own inherited past.

One of the suggested stimulating lesson that challenges negative attitudes towards immigrants includes exploring on the expansion of the British Empire and considering on the differences between what happened in the past and what is currently happening. It was suggested that this would lead nursing students to think of their own inherited past and to embrace a multicultural Britain. Furthermore, the study findings suggested that *nurse educators will at times be required to challenge learners over some of their behaviours that they feel could be potentially discriminatory* [SL8]. Study findings also encouraged nurse educators to challenge stereotypes, prejudice, discrimination and religious intolerance *in order to ensure that they create a learning environment that is free of discrimination and that values differences* [CSM2]. Such an approach is consistence with the requirements of the *Delivering Race Equality in Mental Health Care (DRE)* equalities legal framework (DOH, 2005). DRE was an action plan that required all organisations to have policies and procedures that are aimed at achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status, including those of Irish or Mediterranean origin and east European migrants(DOH, 2005). It was also an action plan to develop a workforce that can deliver equitable care to BME populations in order to improve clinical services for BME populations thereby, improving those services for specific populations (DOH, 2005).



However, *knowing what to challenge, and when to challenge, can be tricky and open to personal interpretation* [SL5] as suggested by some of the nurse educator study participants. At the same time, other study participants suggested that *not challenging* stereotypes, prejudice, discrimination and religious intolerance is not a neutral act, as *it can be seen as colluding behaviour* [SL2]. In terms of how to challenge stereotypes, prejudice, discrimination and religious intolerance, the study participants asserted that *there is no definite way to challenge inappropriate behaviour* and that *each nurse educator would find his or her own approach to challenging effectively* [SL2]. Some nurse educator study participants suggested that inappropriate behaviour in classroom settings *can be challenged by not punishing or blaming the learner, but by understanding your learners and suggesting a better way of saying things* [SL7].

In terms of challenging issues were some nursing students were accusing others of racism or racist statements, nurse educator participants were adamant that their *roles were not to make judgments about whether racism may or may not be taking place* [SL6]. The nurse educator participants further suggested their roles are *to listen to the learners, ask learners to name the problem and how they feel about the problem* [SL2], *and explore how the learner wants to resolve the situation after providing clear options* [SL1], *as well as taking any supportive actions that may be required* [SL9]. Some nurse educator participants felt that inappropriate approach in challenging what could be considered as racial accusations in classroom settings among students *may result in a formal harassment and discrimination investigations being conducted* [SL3].

In conclusion, the study findings and literature suggested that when mental health nursing students consider their attitude and behaviour towards diversity, they are encouraged to identify similarities as well as differences. The study findings also suggested that all those involved in cultural competence education should appreciate that, in contemporary communities, there are similarities as well as differences between people of different race, religion, culture, religion, ability or disability or sexual orientation. The study findings therefore proposes that learning to empathise with others, helps nursing students to take responsibility to challenge stereotypes, prejudices discriminations and religious intolerances, where they are encountered. Therefore, any teaching centred on developing cultural competence should address issues of challenging stereotypes, prejudice and the practice of religious tolerance. The practice of tolerance means accepting the fact that human beings are naturally diverse in their appearance, beliefs, situations, speeches, behaviours and values; and that they have the right to live as they are in peace. In short, those involved in cultural competence education must have an understanding that all forms of

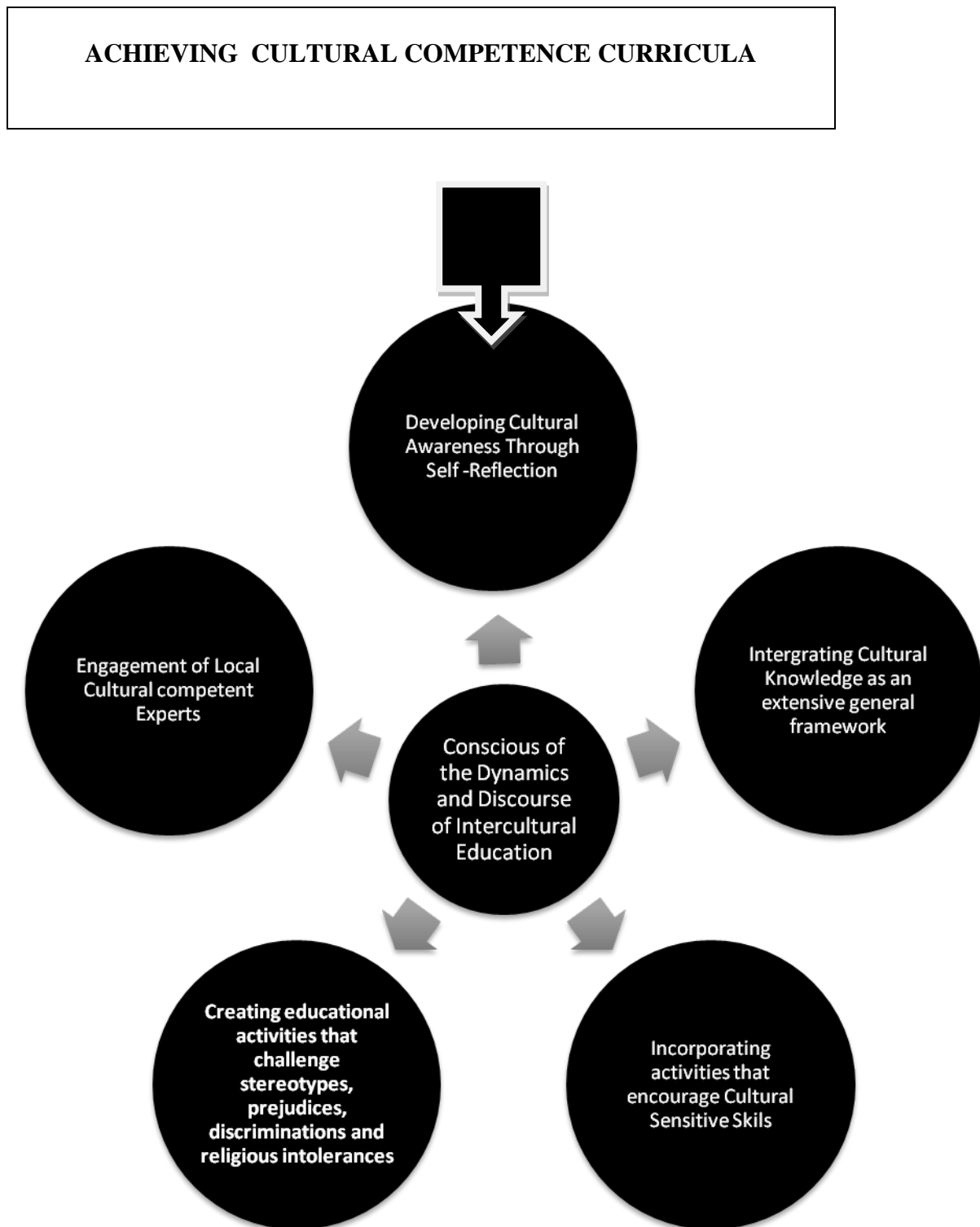
stereotype, prejudice, discrimination and religious intolerance must be challenged at every level in learning and in clinical practice.

#### **5.4: Overview of the central theoretical construct: Conscious of the dynamics and discourse of intercultural education**

The final theoretical construct to be discussed in this section is the core or central theoretical concept, also known by some researchers as core category (Strauss and Corbin, 1998). According to Strauss and Corbin (2008), the core category in grounded theory research is the centrepiece of the theoretical framework or an abstraction that represents the main theme of the research. The grounded theory researchers further mentioned that the core category or concept demonstrates “analytic power” in its ability to ‘pull the other categories together to form an explanatory whole’ (Strauss and Corbin, 1998, p. 146).

In this study, the central or core theoretical concept entitled ‘**Conscious of the dynamics and discourse of intercultural education**’ was determined after examining and piercing together the other three main theoretical constructs and their sub theoretical constructs (see Fig. 4). The central theoretical construct represent differing assumptions, views, values and beliefs of the parties involved in the learning and teaching of a cultural competence inclusive curriculum and how those differing perspectives could be bridged by removing the boundaries among them. In summary, the central theoretical construct reflects not only the actions of participants, but also the underlying assumptions, theoretical perspectives and philosophies that guided the participants’ responses. At a minimum, the central construct suggests that educators should understand how they can make appropriate adaptations and the appropriate support when they encounter some challenges that may arise when designing and teaching cultural competence within the curriculum. The current study findings and literature suggest that when motivation is high, the students tend to be more actively involved in learning.

*Fig. 4: A Conceptual Framework of developing cultural competence*



## **5.5: Limitations of the study overview**

This study is significant as it is the first study of its kind that employed a qualitative grounded theory research design to generate a conceptual framework of developing cultural competence that is grounded in data collected from the perspective of those experienced in the mental health nursing education within the UK context. However, as with all research, this study comes with its own limitations. The study limitations are detailed below.

### **5.5.1: The absence of a systematic literature review**

Whilst the approach the researcher chose was believed to be the best available, given the resources available, it does have a number of weaknesses. For example, a systematic literature review would have provided a more comprehensive list of relevant work and resources related to models and frameworks that have been developed with the aim of developing health care practitioners to provide effective health care that is relevant to people's cultural needs, which in turn would have informed the recommendations made.

### **5.5.2: The small geographical sample and size**

Participants in this study were drawn from seven universities that offer pre-registration mental health nursing training in one strategic health region in the United Kingdom. Therefore, the results of this study may not be generalized to other regions of the country. Rather, they contribute to an evolving understanding of how cultural competence could be integrated within the curriculum from the UK context and the problems that may be encountered during teaching and learning cultural competence issues as well as the possible solutions to the problems. Therefore, the inclusion of only the universities located within only one county of the UK health regions as the research site has no doubt reduced the diversity of experiences which could potentially be obtained from other participants if numerous sites had been used. In addition, not all cultural groups were represented in this study. It is possible that nursing students as well as nursing educators of different cultural groups or ethnicities would not respond in the same manner.

Additionally, more time would have enabled the researcher of the current study to extend and refine his recommendations. In particular, it would have been helpful to speak to a wider variety of student nurses, nurse educators particularly from all the UK health strategic regions. The largest weakness is the limited numbers of clinical nurse educators' perspective in the interviews. Considerable efforts were made to engage more from this group, however given the ongoing changes as a result of the NHS restructuring of staff exercise, it was perhaps not particularly surprising this was difficult to achieve. A broader sample size of nurse educators may have provided a more representative picture of the perspectives of the key participants within the UK undergraduate nursing training context, especially from the clinical settings.

### **5.5.3: The presence of the researcher as the data collection tool**

The presence of the researcher as the data collection tool could possibly be one of the limitations in this study. For instance, the researcher conducted all the interviews and collected all the curricula documents and such could have some limitations. This may be because cultural competence is a topic that some people find it difficult and sensitive to discuss as *it invites issues of racism and superiority of identities* according to the study participants. The fact that the researcher is from ethnic minority background, the study participants could have found it more difficult to discuss some of the issues in great detail as the researcher may have been deemed to represent the interest of the minority cultures as expressed by one senior lecturer who gave the comment below.

*“..... of course I really appreciate and understand the concerns in your research, probably from experience and encounters you or your colleagues, relatives friends might have had or a bad experience from the care given by nurses, ..... [SL4]*

Although the senior lecturer referred to the care given to the researcher and his ethnic minority colleagues, the researcher was not eliciting such responses. Therefore, it could be argued that the researcher's ethnic minority membership group might have limited the data being collected.

#### **5.5.4: Possibility of bias in the researcher's report of findings**

Finally, another possible limitation of the study findings could be argued that the report findings may be biased by the researcher's interpretations, as well as the data could have been impacted by the presence of the researcher. Given that interpreters interpret things differently, it is possible that the researcher had his own biases to overcome or consider when carrying out the data analysis and discussions which also included inductive reasoning processes. For example, the researcher could have paid more attention to the responses he agreed with and less attention to what he disagreed with and also to comments that supported his ideas and beliefs. Obviously, this qualitative grounded theory approach to data analysis used by the researcher could have caused results to be unreliable, and readers should certainly be aware of the possibility of bias in the researcher's report of findings.

Further, the presence of the researcher as a data collection tool could have impacted on data. The researcher being an individual coming from an ethnic minority background and researching on the topic which is centred on people from minority ethnic background could have been seen by the study participants as trying to find ways of prioritising minority issues. It then could be argued that participants gave responses to suit the researcher's purpose and that the researcher could have paid more attention to what he considered appropriate for the study topic. Therefore, for future qualitative grounded theory research approaches in the same area, the researcher of this study is suggesting multiple coding to be included in order to add rigour. Multiple coding methods was defined by Mays and Pope (1995) in their qualitative study as involving two or more researchers in analysing the same data set and then comparing and discussing their findings with the aim of reducing investigator bias.

## 5.6: Study conclusions

This study represents a first attempt to develop a conceptual framework of developing cultural competence within the UK context based on the perspectives of those directly experiencing the undergraduate mental health nursing education, using qualitative grounded theory approaches. The developed conceptual framework in this study is accomplished by three main theoretical constructs, five sub theoretical constructs and thirteen themes that represented how study participants responded.

The theoretical construct of **dissatisfaction with how aspects of cultural issues are portrayed in current curricula** revealed some frustration and disappointment with regard to the current curricula. This is because many study participants felt that **discussions on cultures bring issues of racism, conflict and controversy**, as well as that **education centred on cultures brings boredom in class as it appears to be irrelevant to the future** and that the **inadequate cultural competence teaching resources and educators' lack of knowledge hinder the development of cultural competence education**. This theoretical construct revealed that undergraduate mental health nursing students who participated in the study were provided with some level of cultural competence education. However, the study findings seem to suggest that the approaches that were taken were either inadequate, inconsistent and or that such cultural issues were dissatisfactory presented in the curricula. This construct therefore paved way for the need of conceptual framework of developing cultural competence that can be used as a guideline.

Binding the other theoretical constructs is the central theoretical construct labelled **conscious of the dynamics and discourse of intercultural education**. The central theoretical construct of the **conscious of the dynamics and discourse of intercultural education** revealed that some tensions were evident in the differences of opinion regarding of cultural competence inclusive education curriculum. Some study participants were saying that **issues of culture are inadequately or marginally incorporated in curricula** while others were saying that **issues of cultural competence are incorporated in other modules although consistence and quality of training might vary from institute to institute**. Those study participants further commented that the ethical responsibilities to make sure those cultural issues are fully addressed within the curricula rest with the individual senior lecturers. One position emergent from the data was that cultural issues relevant to a particular client should be determined in each specific case through



the nurse educator exploring cultural factors with his or her students in classroom environment and researching the pertinent cultural issues outside the classroom, such as on clinical placement if necessary. For study participants, cultural competent courses embedded in other modules such as Sociology of health and Illness, Diversity Awareness etc provide a solid foundation for beginning the process of cultural competence education. The central theoretical construct depicts that developing cultural competence within a diverse classroom environment is a slow process that requires all those participants who are involved in the process to be conscious of the dynamics and discourses that might result from differing ideological views. As a result, the involved people's views and identities are challenged by other people's ways of doing and thinking, and this occurs not always without conflict.

A conceptual framework of developing cultural competence emerged as identified by the theoretical **achieving cultural competence curricula**. The construct is composed of five sub constructs namely:

1. **Developing cultural awareness through self reflection**
2. **Integrating cultural knowledge into the curriculum as an extensive general framework**
3. **Incorporating activities that encourage effective cultural sensitive skills**
4. **Engagement of local experts to assist in teaching cultural competence specific areas and**
5. **Creating educational activities that challenge stereotypes, prejudices, discriminations and religious intolerances**

The development of cultural competence is considered by many cultural competent experts to be a lifelong process or journey during which the individual continually grows in awareness, knowledge and skills (Leninger, 1991; De La Cancela et al., 1998; Campinha-Bacote, 1999; Papadopoulos, 2006). The sub theoretical construct of **developing cultural awareness through self reflection** was considered by both the literature and the study participants as one of the strategies and the departure point in the process or journey of developing cultural competence. The sub construct emphasizes self-reflection of one's own cultural identity and cultural beliefs as one of the most important facet to developing cultural competence and therefore requires both learners and nurse educators to begin by "self reflection" in order to reframe their prior assumptions, take alternative perspectives, and recognize their induced roles and come to

understand how their perceptions were formed. Therefore, self reflection is believed to foster self awareness.

The sub theoretical constructs of **integrating cultural knowledge into the curriculum as an extensive general framework** revealed a range of views on the cultural competence education experience, its contribution to the competence of student nurses, and on how it could be improved. For most study participants, the current curriculum was not considered to have adequately addressed the issues of culture and its influence in the practice of mental health nurses and did not appear to cover cultural competence in the level of detail that is evident in the literature as demonstrated by theme 1 of the results chapter. Study participants asserted *that issues of culture were marginally incorporated in the curriculum to cover the legal and professional requirements [SN7]*. Some student nurse participants claimed that *the issues of culture were covered a lot throughout the undergraduate nursing curriculum but, not in a meaningful depth to distinguish stages of progression [SN3]*. They further claimed that *learning the same issues every time throughout the three years becomes boring and is not helpful [S1FG2]*. As a result, study participants expressed the need for reflective space to consider cultural issues in more details and to have access to *cultural competent experts such as community leaders and ex-service users to come as visiting lecturers [SN5; SN7]*. Study participants suggested *the need for comprehensive cultural knowledge to be integrated into the mental health nursing curriculum [SN5]*, such as *balancing between generic and specific cultural knowledge* as well as the knowledge of the traditions, beliefs, values, and family dynamics of a cultural group etc. They also suggested having the *knowledge on how diverse people built, shaped, defended, and helped the nations including theirs*. Such study findings are consistent with literature that suggest that ‘cultural knowledge is required in order to understand the similarities and differences of cultural groups as well as the inequalities in health within and between groups’ (Papadopoulos et al., 2004, p. 109).

**Incorporating activities that encourage cultural sensitive skills within the curriculum** is another sub theoretical construct that emerged as an important theme in the development of cultural competence within the undergraduate nursing curriculum. The sub construct suggests that one of the ways of building student nurses’ cultural sensitive skills is through subjecting them to intercultural experiences during their university based learning activities and clinical placement activities. The activities that were considered to promote cultural sensitive includes but not limited

to effective communication skills, interpersonal skills, use of interpreters, relationship building skills, issues of holistic patient centred approach, establishing good rapport and trust with clients, good negotiation skills, challenging and dealing with any forms of discriminations and prejudice, as well as subjecting nursing students to intercultural experiences in appropriate clinical settings.

The **engagement of local experts to assist in teaching cultural competence specific areas** was one of the sub construct that was viewed as important strategy when developing cultural competence. This sub construct emphasises the importance of engaging local community members, service users and cultural competence experts when addressing issues of cultural competence within the pre-registration mental health nursing curriculum as it benefits both the teachers and those taught.

**Creating educational activities that challenge stereotypes, prejudices, discriminations and religious intolerances** is another sub theoretical construct that is also an important strategy used when developing cultural competence. The strategy encourages and prepares future practitioners to be able to challenge any forms of stereotypes, discriminations, prejudices and religious intolerances both in classroom environments and in clinical settings when developing cultural competence and when implementing culturally competent care in practice respectively.

In summary, the study participants' views in this research are often on target in terms of current thinking of what constitute a cultural competence inclusive curriculum (Papadopoulos, 2006). The current study findings revealed a degree of consistency between the views and perspectives of the study participants (nurse educators and nursing students) and what the literature describes as some of the cultural competence models and or frameworks (Leininger, 1991; Giger and Davidhizar, 1999; Papadopoulos, 2006; Campinha-Bacote, 2007). The main theoretical constructs emerging from the study fit into a cultural competence frameworks encompassing awareness, knowledge and skills (Papadopoulos, 2006).

Whilst some of the themes and theoretical constructs emerging from the results of the interview data were generally consistent with those indicated in the cultural competence literature, there were some other themes that emerged from the study participants on what was required within the curriculum in order to educate student nurses in ways that will enable them to work effectively and culturally appropriately with clients from diverse cultural backgrounds. The additional bridging theoretical construct included **conscious of the dynamics and discourse of**

**intercultural education** which was a result of the differing ideological views about current curricula and how issues of cultural competence could best be addressed within the curricula. The strategies of **engagement of local experts to assist in teaching cultural competence specific areas** and also the **challenging discriminations and prejudice by encouragement of open discussions on privileged and marginalised groups when addressing issues of cultural competence** where also additional reinforcement theoretical constructs to those in the current cultural competence literature.

### **5.7.1: Implication for education and practice**

The developed conceptual framework has implications for education and practice. The conceptual framework for developing cultural competence in this study may have direct application to UK undergraduate mental health nursing education as it is a direct result of the subjective experiences of the key participants within the undergraduate mental health nursing education on how they view their own situation and what they consider as essential to plan and deliver a curriculum that is capable of creating a workforce who can deliver the highest quality care to every patient regardless of cultural affiliation. The three main theoretical constructs and their related sub constructs as well as the thirteen emerged themes can serve as a guide for the development of curriculum for undergraduate and post graduate education courses within mental health nursing and other health related courses.

This study therefore, challenges all undergraduate nursing education programmes to thoughtfully consider how they implement and integrate cultural competence within their curricula and whether they are effective in the process in relation to their political or social context. In so doing, the nursing education programs can move closer to the goals identified by the professional bodies (ENB, 1997; NMC, 2002; QAA, 2009), Department of Health (DOH, 2005), the principles of Social Justice (Rawls, 1971; Douglas et al, 2009) and nursing literature (Leininger, 1995; Campinha-Bacote, 1999; Bhui et al, 2007) of educating nurses who are capable of effectively working with clients from diverse cultural backgrounds irrespective of geographical location. The conceptual framework also provides a new lens for thinking about how to intervene, approach, and interact with diverse student group therapeutically when educators are creating a workforce that is capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, colour or creed. For direct undergraduate mental health nursing education, the developed conceptual framework allows for the explicit delineation of teaching cultural competence through five sub theoretical constructs that represented how study participants responded as well. Finally, the emergent conceptual framework also has implications for those involved in the planning, developing and teaching the healthcare and allied healthcare curricula and possibly any education curricula that involves diverse student groups.

### **5.7.2: Implications for future research studies**

The findings from this study suggest pathways for future research. First, researchers may consider using qualitative grounded theory approach methodology to explore the experiences of a larger or possibly a more representative group of senior lecturers, student nurses, clinical sign-off mentors and student clinical mentors.

Secondly, the researchers may consider drawing their participants from more representative geographical regions because, as discussed in the limitations section, the current study participants were all drawn from the West Midlands Health Region, which is only a single small geographical region of the United Kingdom. Research evidence from Lasala (2000) seem to suggest that individuals from different geographical regions approach cultural competence nursing care issues differently due to vast differences in cultural and ethnic make up of the settings and consequently, they may have different experiences of implementing cultural competence within the curriculum for their diverse classroom environments. Future work may also aim to include more educators from the clinical side such as clinical mentors and clinical sign-off mentors in the sample and increase the representation from different geographical regions of the United Kingdom.

Thirdly, future research studies may consider investigating from patients' perspectives on what constitutes cultural competence curricula within the UK mental health context. The reason is because in this current study, the primary data sources were from student nurses and nurse educators involved in pre-registration of mental health nursing training. Furthermore, the secondary data sources used in this study were also concentrated on the curricula documentation materials used by the same study participants.

Finally, this study has got implications for further research in terms of opening new avenues for global nursing and other allied health care education systems to think of having frameworks that are relevant and applicable to their own contexts and thereby eliminating the one size fits all approach in terms of educational conceptual frameworks.

## **5.8: Transferability of findings**

Transferability of findings depends upon whether readers recognize the developed conceptual framework of developing cultural competence within UK mental health nursing education context. Readers from other health care related settings such as occupational health, physiotherapy, medicine and so on may also recognize theoretical constructs that emerged from the current study as well as the dynamics and discourses of intercultural interactions when attempting to design and implement cultural competence curriculum that is relevant and inclusive to diverse learners in their encounters in education settings. It is hoped that this work contributes to the continued dialogue about developing cultural competence from the perspective of those directly involved in the education system. Therefore, the emergent conceptual framework of offers a new lens or fresh vision for defining and celebrating key participants in the mental health nursing education's contribution to cultural competence education within the UK context.

The researcher of this study acknowledges that there may not be one single cultural competence framework that reflects all of the values of the global cultural competence nursing education curricula, but the researcher of this study hopes this work and the emergent framework embodies a “best practices” approach that will enhance the implementation of cultural competence in mental health nursing education applicable to the UK nursing context.

## **5.9: What this research study adds: Contribution to Knowledge**

This study is significant as it represents the first attempt to develop a conceptual framework of developing cultural competence within the UK context based on the perspectives of those directly experiencing the undergraduate mental health nursing education, using qualitative grounded theory approaches. Exploring and developing the conceptual framework from the perspectives of the neglected silent voices of the key participants who are directly involved in the undergraduate nurse training within the UK context, contributes to the existing research in this area and provides a view not currently presented in the nursing literature.

Whilst the researcher of this study sincerely acknowledges other nursing scholars who also have been adding to the field with conceptual models and approaches that push the frontiers of cultural competence nursing, their approaches appeared either technically complex to implement or inappropriate to the UK nursing education context. For instance, the works of, but not limited to Papadopoulos (2006), Campinha-Bacote (2002), Purnell and Paulanka (1998), Giger and Davidhizar (1999), Leininger (1995) and others are great contributions to the literature base as they used empirical methods to identify competencies needed by staff to work with diverse client groups. The conceptual framework generated in this study expands this literature by providing evidence to support the approaches of some of the conceptualisations regarding some of the strategies and approaches to cultural competence. The proposed conceptual framework of teaching cultural competence is intended as a guide to enable core knowledge, skills and attitudes specific to developing cultural competence to be addressed in the delivery of nurse education programs.

The study findings have therefore extended and advanced the existing knowledge of developing cultural competence within the UK undergraduate mental health nursing education. The developed conceptual framework may also be useful to health care professionals and could be applied in multidisciplinary practices. Therefore, the researcher of this study holds that this developed conceptual framework makes an original contribution to establish and advance cultural competence education knowledge, research and practice. Therefore, this study offers new lens or fresh vision for defining and celebrating key participants in the mental health nursing education's contribution to cultural competence education within the UK context.





## APPENDICES

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## **Appendix 1: Senior Lecturers' Interview Guide**

<b>Interview process/outline</b>	<b>NOTES/HIGHLIGHTS/CLARIFICATION POINTS</b>
<ul style="list-style-type: none"><li>• Thank you</li><li>• My name</li><li>• Purpose</li></ul> <ol style="list-style-type: none"><li>1. Duration – less than 1 hour</li><li>2. How interview will be conducted</li><li>3. Confidentiality</li><li>4. Opportunity for questions</li></ol> <p>Acknowledgment of Consent</p> <ol style="list-style-type: none"><li>5. Curriculum documentation materials</li></ol>	

1) Which groups of students are you directly involved with, within the university/department?

2) What are your main responsibilities?

3) When did you become part of the university staff?

.....

1) How do you understand the term "cultural nursing care"?

2) What do you consider to be the main cultural nursing care issues that need to be addressed within the mental health nursing curriculum?

3) What do you consider to be the main issues that nurse educators should be focussing on when designing the courses to prepare students for work with diverse population?

.....

1) What do you think should be taught at pre-registration mental health nurse training about cultural nursing care?

- 2) What main topics do you think that cultural nursing care teaching should encompass at pre-registration training?
- 3) What do you consider to be the main issues that nurse educators should be focussing on when addressing the care needs of people from diverse cultural backgrounds?
- 4) At which stage of the pre-registration student nurse career should cultural nursing care teaching take place?
- 5) How much time do you think needs to be spent teaching cultural nursing care?
- 6) What teaching strategies or approaches might be usefully employed when addressing cultural nursing care?
- 7) Who do you think should teach cultural nursing care?
- 8) How do you think cultural nursing care should be taught? – As a separate module or encompassed in other modules?
- 9) What kind of learning outcomes would you like to see established for cultural nursing care?
- 10) Where do you think the current curriculum stands in relation to addressing the care needs of local population?  
.....
- 1) What skills and knowledge would you prefer the nursing graduates to have that would prepare them for work with diverse population?
- 2) How do you prefer such skills and knowledge to be addressed within the curriculum?
- 3) How do you prefer such skills and knowledge to be assessed within the curriculum?
- 4) Are you aware of any guidelines on how cultural nursing care could be addressed within the curriculum? Please say them (if any).
- 5) What are the sources of such guidelines (if any)?

6) How do you prefer such guidelines to be constructed?

.....

- 1) How do you prefer students to be assessed as evidence of achievement of learning outcomes of cultural nursing care?
- 2) How do you prefer student feedback to be gathered on their involvement in cultural nursing care training?
- 3) How might student feedback be effectively used?
- 4) What might be your perspective if students said that they did not feel this kind of teaching necessary?
- 5) Would it be helpful to have guidelines on what should be taught on cultural nursing care?
- 6) What form would you prefer the guidelines to take and who do expect to develop them?  
.....

- 1) What specific training programmes to teach cultural nursing care are you aware of?
- 2) In your view, could these training programmes form models of best practice?
- 3) In your opinion, how do you think programmes that endeavour to teach cultural nursing care might be evaluated?
- 4) In your view, does the teaching of cultural nursing care have an impact on clinical practice?
  - a. If no, can you think of reasons why this might be the case?
  - b. If yes, can you think of how it impacts on practice?  
.....

For the key terms I am going to ask you, I should say that there is no right or wrong answer as such. I am just interested in your views?

- 1) What is your understanding of the following terms?

- a. Culture
- b. Cultural competence
- c. Cultural competent care
- d. Cultural nursing
- e. Multicultural nursing
- f. Transcultural nursing
- g. Ethnicity
- h. Race

1. How do you think that the way that these terms are used and understood might influence nursing education?

.....

- 1) What are some of the barriers that are likely to be encountered by educators when teaching cultural nursing care within the curricula? (Lack of key support? Lack of technical assistance?)
- 2) How do you prefer those barriers to be overcome or addressed?
- 3) Do you have any personal training/experience in cultural nursing care issues?
- 4) What are some of the development opportunities which are available to staff that enable them to effectively teach cultural nursing care within the curriculum?
- 5) What are the situations you encounter in your day-to-day teaching practice that will help me to understand what you mean by the discussion which are focused on culture invites issues of racism?
- 6) What strategies can be taken to integrate the value of tolerance in the curriculum?
- 7) What else can be done to challenge prejudice and discrimination among groups of diverse students?

- .....
- 1) How would you classify your own ethnicity?
  - 2) Is there anything else that you would like to add – either more about what we have covered or anything you feel I may have left out?
  - 3) What recommendations and improvements do you have for future that could be used when teaching cultural nursing care?

<b>Curriculum documents</b>	I would appreciate if you could supply me with any curriculum documents, syllabus, module guides or material which you normally use within the mental health nursing curriculum – focussing specifically on cultural nursing care.
<ul style="list-style-type: none"> <li>•</li> <li>• Next steps</li> <li>• Thank you</li> </ul>	<p>Well, it has been a pleasure finding out more from you. I will be analyzing the information you and others gave me and submitting a draft report to the university of Wolverhampton in due course. I will be happy to send you a copy to review at that time, if you are interested. If it is necessary, may I contact you again to seek further clarification on what we have discussed today?</p> <p>Thank you very much for your help with this project.</p>

## Appendix 2: Student Nurses' Interview Guide

Interview process/outline	NOTES/HIGHLIGHTS/CLARIFICATION POINTS
<ul style="list-style-type: none"><li>• Thank you</li><li>• My name</li><li>• Purpose</li></ul> <ol style="list-style-type: none"><li>5. Duration – less than 1 hour</li><li>6. How interview will be conducted</li><li>7. Confidentiality</li><li>8. Opportunity for questions</li></ol> Acknowledgment of Consent	

1. Tell me about your course progress to date?
2. How far are you in your nurse training?
3. When did you start your nurse training?
4. When are you finishing your nurse training?
5. Where do you intend to work when you finish your course?
6. What are some of the nursing care needs of patients whose cultural backgrounds are different from the White majority? Please list.
7. What methods and materials are currently being used when addressing the nursing care needs of the diverse people with mental health problems within your curriculum?
8. What do you consider to be the key issues that need addressing within the curriculum/program to prepare student nurses for work with diverse population?



9. How do you prefer those key issues to be addressed within the curriculum/program?
10. Coming back to how the nursing care needs of the diverse population were addressed within the curriculum, what do you think about the content?
11. Imagine you were the lecturer on this course. Can you think of other ways of addressing the nursing care needs of the diverse population within the curriculum?
12. Will you do anything differently?
13. What are your suggestions for improvement?
14. Imagine once again that you were the lecturer on this course. Can you think of other ways of designing the course/program in order to prepare student nurses for work with diverse population?
15. Will you do anything differently?
16. What are your suggestions for improvement?
17. Is there anything else that you would like to add – either more about what we have covered or anything you feel I may have left out?

Well, it has been a pleasure finding out more from you. I will be analyzing the information you and others gave me and submitting a draft report to the University of Wolverhampton in due course. If it is necessary, may I contact you again to seek further clarification on what we have discussed today?

Thank you for your time.

### Appendix 3: Clinical Nurse Educator Interview Guide

Interview process/outline	NOTES/HIGHLIGHTS/CLARIFICATION POINTS
<ul style="list-style-type: none"><li>• Thank you</li><li>• My name</li><li>• Purpose</li></ul> <p>9. Duration – less than 1 hour</p> <p>10. How interview will be conducted</p> <p>11. Confidentiality</p> <p>12. Opportunity for questions</p> <p>Acknowledgment of Consent</p>	

1. Talk with me about your mentoring/assessing role.
2. What do you do on a day-to-day basis in your mentoring/assessing roles with nursing students in this setting?
3. When did you become part of the clinical assessor/sign off mentor?
4. How did you come to mentor/assess students?
5. Which groups of students are you directly involved with, within the clinical placement?
6. How do you feel about what you do in mentoring/assessing on a day-to-day basis?
7. What are your main responsibilities?
8. Please describe an actual experience you have had with nursing students working with patients in the clinical setting that will help me understand what cultural competence means to you.

9. How do you understand the term "cultural nursing care"?
10. What do you consider to be the main cultural nursing care issues that need to be addressed within the mental health nursing curriculum?
11. What do you consider to be the main issues that nurse educators should be focussing on when designing the courses to prepare students for work with diverse population?
12. What do you think should be taught at pre-registration mental health nurse training about cultural nursing care?
13. What main topics do you think that cultural nursing care teaching should encompass at pre-registration training?
14. What do you consider to be the main issues that nurse educators should be focussing on when addressing the care needs of people from diverse cultural backgrounds?
15. At which stage of the pre-registration student nurse career should cultural nursing care teaching take place?
16. How much time do you think needs to be spent teaching cultural nursing care?
17. What teaching strategies or approaches might be usefully employed when addressing cultural nursing care?
18. Who do you think should teach cultural nursing care?
19. How do you think cultural nursing care should be taught? – As a separate module or encompassed in other modules?
20. What kind of learning outcomes would you like to see established for cultural nursing care?

21. Where do you think the current curriculum stands in relation to addressing the care needs of local population?
22. What skills and knowledge would you prefer the nursing graduates to have that would prepare them for work with diverse population?
23. How do you prefer such skills and knowledge to be addressed within the curriculum?
24. How do you prefer such skills and knowledge to be assessed within the curriculum?
25. Are you aware of any guidelines on how cultural nursing care could be addressed within the curriculum? Please say them (if any).
26. What are the sources of such guidelines (if any)?
27. How do you prefer such guidelines to be constructed?
28. How do you prefer students to be assessed as evidence of achievement of learning outcomes of cultural nursing care?
29. How do you prefer student feedback to be gathered on their involvement in cultural nursing care training?
30. How might student feedback be effectively used?
31. What might be your perspective if students said that they did not feel this kind of teaching necessary?
32. Would it be helpful to have guidelines on what should be taught on cultural nursing care?
33. What form would you prefer the guidelines to take and who do expect to develop them?
34. What specific training programmes to teach cultural nursing care are you aware of?

35. In your view, could these training programmes form models of best practice?
36. In your opinion, how do you think programmes that endeavour to teach cultural nursing care might be evaluated?
37. In your view, does the teaching of cultural nursing care have an impact on clinical practice?
- c. If no, can you think of reasons why this might be the case?
- d. If yes, can you think of how it impacts on practice?

.....

For the key terms I am going to ask you, I should say that there is no right or wrong answer as such. I am just interested in your views?

- 2) What is your understanding of the following terms?
    - i. Culture
    - j. Cultural competence
    - k. Cultural competent nursing care
    - l. Cultural nursing
    - m. Multicultural nursing
    - n. Transcultural nursing
    - o. Ethnicity
    - p. Race
  2. How do you think that the way that these terms are used and understood might influence nursing education?
- .....
- 8) What are some of the barriers that are likely to be encountered by educators when teaching cultural nursing care within the curricula? (Lack of key support? Lack of technical assistance?)
  - 9) How do you prefer those barriers to be overcome or addressed?

- 10) Do you have any personal training/experience in cultural nursing care issues?
- 11) What are some of the development opportunities which are available to staff that enable them to effectively teach cultural nursing care within the curriculum?
- 12) What strategies can be taken to integrate the value of tolerance in the curriculum?
- 13) What else can be done to challenge prejudice and discrimination among groups of diverse students?
- 4) How would you classify your own ethnicity?
- 5) Is there anything else that you would like to add – either more about what we have covered or anything you feel I may have left out?
- 6) What recommendations and improvements do you have for future that could be used when teaching cultural nursing care?

Well, it has been a pleasure finding out more from you. I will be analyzing the information you and others gave me and submitting a draft report to the University of Wolverhampton in due course. If it is necessary, may I contact you again to seek further clarification on what we have discussed today?

Thank you for your time.

#### **Appendix 4: Dean/HOD Request permission top letter**

Professor XXX by **seven names**

Dean of School of Health

University of XXXXXCX

February 2009

Dear Professor XXX by seven names

As part of my PHD degree at the University of Wolverhampton, I am conducting a research project which aims to explore and identify the parameters and features that should underpin a curriculum that addresses cultural care issues within the pre-registration mental health nurse training.

I am therefore writing to seek your permission to approach senior lecturers (award leaders) and the 3<sup>rd</sup>. year mental health nursing students within the pre-registration mental health nursing training, and enclose a copy of the research proposal for your information.

This study may not give participants direct personal benefit from taking part. However, this study may benefit the participants (educators/curriculum developers and student nurses), as their participation in the study will make them more informed of the current issues, challenges, opportunities and policies of best practice regarding the cultural competence nursing care.

I will be analyzing the information I will submit a draft report to the University of Wolverhampton. I will be happy to send you a copy to review at that time, if you are interested. A full written report will be prepared for the University of Wolverhampton and dissemination and publication strategy will be developed.

I have attached a sample brief outline of the proposal that was approved by the University of Wolverhampton Ethics Committee for your information.

I look forward to hearing from you.

Yours sincerely

Ray E. Mbambo

## **Appendix 5: Educators/ Deans/ HOD Information Sheet**

### **Participant information sheet for Educators/Curriculum Developers/Senior Lecturers**

Study title: **Cultural care issues in undergraduate nurse training of Mental Health Nurses: Parameters and Features that should underpin a Curriculum**

Researcher: Ray Mbambo

#### **Invitation to the study paragraph**

You are being invited to take part in a research study. Before you decide, it is important that you do understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If anything is unclear or you would like more information about this study, please do not hesitate to ask. Take time to decide whether or not you wish to take part. Thank you for reading this invitation paragraph.

#### **What is the purpose of this study?**

The principal aim of the research is to explore and identify the parameters and features that should underpin a curriculum that addresses cultural nursing care issues within the pre-registration mental health nurse training.

#### **Why have I been chosen?**

You have been asked to take part in this study because you are a senior lecturer, award leader, principal lecture, curriculum developer or course coordinator within the pre-registration mental health nurse training with related experience, and are therefore in a better position to make valuable comments and detailed feedback on issues that are of concern to this student group.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep. The information you provide will be helpful in the exploration and identification of the parameters and features that should underpin a curriculum that addresses cultural nursing care within the pre-registration mental health nurse training. If you decide to take part you are still free to withdraw at any time and without giving a reason.



**What will happen to me if I decide to take part?**

If you decide to take part you may be asked to participate in the one to one interviews with myself. The interviews are easy to participate and there are no right or wrong answers. I will be available to answer any questions that you might have. One to one interviews will take approximately 30 minutes to complete. All interviews will be audio recorded and later transcribed. All information will be securely stored until the study is finished, when it will be destroyed. In addition, any information you give will be strictly confidential, and nobody other than myself will be able to access your data. Your name will not appear anywhere in the final report and if your comments are used, these will be anonymous.

**What are the possible benefits of taking part?**

This study may not give you direct personal benefit from taking part. However, your participation in the study will make you more informed of the current issues, challenges, opportunities and policies of best practice when addressing cultural nursing care within the pre-registration mental health nurse training. Your opinions are very important to this study.

**What will happen to the results of the research study?**

A copy of the results of the study will be made available and kept at the University of Wolverhampton. The results of the study may be published in the peer reviewed journals and anybody including participants will be free to read them.

**Who has reviewed the study?**

The University of Wolverhampton Research Ethics Committee has reviewed the study to ensure that it has been well planned.

**Contact for further information**

For further information, or if you do not understand any aspects of this research study then contact **Ray Mbambo on 07958264507 or email [Ray.Mbambo@wlv.ac.uk](mailto:Ray.Mbambo@wlv.ac.uk) or [embambo@hotmail.com](mailto:embambo@hotmail.com).**

Thank you for taking party to read this information.

## Consent Form and Right to Withdraw

**NB: If you are happy to take part please tick the boxes below and contact me to arrange a suitable date for the interviews. You can give this form to me when I visit you for the interviews.**

### **Title of Project:**

**Cultural care issues in undergraduate nurse training of Mental Health Nurses: Conceptual Model of Good Practice**

**Name of Researcher:** Ray Mbambo

**Please tick box**

1. I confirm that I have read and understand the information sheet dated February 2009, for the above study and have had the opportunity to consider the information and ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I agree to take part in the above study. ☐
4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐
5. I agree for this to be audio recorded and for the data to be used for the purpose of this study. ☐

.....

## **Appendix 6: Nurse Educator Participant Invitation Letter**

Dear Senior Lecturer

I am writing to invite you to participate in a research project, which I am conducting as part of my PHD study at the University of Wolverhampton

The principal aim of the research is to explore and identify the parameters and features that should underpin a curriculum that addresses cultural nursing care within the pre-registration mental health nurse training.

The proposal was approved by the University of Wolverhampton Sub Ethics Committee.

Permission to undertake the study in the school has been given by.....**HOD/Dean**

The participation involves taking part into one to one interviews with myself and would take approximately 30 minutes. The interviews would take place at your own institution at a time and place that is convenient to you. The interviews will be audio recorded with your permission. A report will be written of the findings and anonymous names will replace all names so that you and your institution cannot be identified.

NB: If you feel that you would like to take part please email me with the possible dates and times that are suitable to you. If you would prefer not to be involved, please let me know so that I would not bother you by sending reminders. If you decide not to be involved I would like to assure you that your work will not be affected in any way.

I have attached an information sheet, which explains the title and aims of the project for your information.

Yours sincerely

Ray Mbambo

Email: embambo@hotmail.com

07958264507

## **Appendix 7: Student Nurse Invitation Letter**

Dear Student

I am writing to invite you to participate in a research project, which I am conducting as part of my PHD degree at the University of Wolverhampton. I enclose an information sheet, which explains the title and aims of the project.

If you are willing to be involved in taking part, this would involve participating in focus group discussions and/or one to one interviews depending with your preferences. The focus group discussions and or the interviews would take no longer than 30 minutes. Anything you say would be totally confidential and any notes made as a result of the interview and focus group discussions would be destroyed afterwards. The interviews and discussions would take place at your own institution at a time that is convenient to most participants. The interviews and group discussions will be audio recorded. A report will be written of the findings and anonymous names will replace all names so that you cannot be identified.

If you feel that you would like to take part please let your tutor know so that he or she can put your name on one of the focus groups. Preferably you can contact me directly especially if you prefer one to one interviews. If you would prefer not to be involved, please destroy this letter. If you decide not to be involved I would like to assure you that your studies will not be affected in any way.

Yours sincerely,

Ray Mbambo

Tel 07958264507

Email: embambo@hotmail.com

## **Appendix 8: Student Nurse Information sheet, Consent and right to withdraw Form**



### **Study title**

#### **Cultural care issues in undergraduate nurse training of Mental Health Nurses: Conceptual Model of Good Practice**

Researcher: Ray Mbambo

### **Invitation to the study paragraph**

You are being invited to take part in a research study. Before you decide, it is important that you do understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If anything is unclear or you would like more information about this study, please do not hesitate to ask. Take time to decide whether or not you wish to take part. Thank you for reading this invitation paragraph.

### **What is the purpose of this study?**

The principal aim of the research is to explore and identify the parameters and features that should underpin a curriculum that addresses cultural nursing care issues within the pre-registration mental health nurse training.

### **Why have I been chosen?**

You have been asked to take part in this study because you are a student in your final year of pre-registration mental health nurse training with related experience, and are therefore in a better position to assess the entirety of your nurse training experiences. In addition, you are also in a better position to evaluate your preparedness for practice at the completion of your nurse training.

### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to tick a consent form. The information you provide will be helpful in the exploration and identification of the parameters and features that should underpin a curriculum that addresses cultural nursing care within the pre-registration mental health nurse training. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of nurse training you receive.

### **What will happen to me if I decide to take part?**

If you decide to take part and you are a third year pre-registration mental health nurse student, you may be asked to participate in one of the group discussions and or one to one interviews with myself. The group discussions and interviews are easy to participate and there are no right or wrong answers. I will be available to answer any questions that you might have. One to one interviews will take approximately 30 minutes to complete and the group interviews will last approximately 30 minutes. All interviews will be audio recorded, and all information will be securely stored until the study is finished, when it will be destroyed. In addition, any information you give will be strictly confidential, and nobody other than me will be able to access your data. Your name will not appear anywhere in the final report and if your comments are used, these will be anonymous.

### **What are the possible benefits of taking part?**

This study may not give you direct personal benefit from taking part. However, this study may benefit you when you take part, as your participation in the study will make you more informed of the current issues, challenges, opportunities and policies of best practice regarding the care given to culturally diverse clients and how such skills may be addressed within the curricula. Your opinions are very important to this study.

### **What will happen to the results of the research study?**

A copy of the results of the study will be made available and kept at the University of Wolverhampton. The results of the study may be published in the peer reviewed journals and anybody including participants will be free to read them.

**Who has reviewed the study?**

The University of Wolverhampton Research Ethics Committee has reviewed the study to ensure that it has been well planned.

**Contact for further information**

For further information, or if you do not understand any aspects of this research study then contact

**Ray Mbambo on email [embambo@hotmail.com](mailto:embambo@hotmail.com).**

Thank you for taking party to read this information.

**Student Nurse Consent and right to withdraw form**

**NB: If you are happy to take part please tick the boxes below and contact your tutor or me to arrange a suitable date for the interviews or group discussions. You can give this form to me when I visit you for the interviews.**

Title of Project: **Cultural care issues in undergraduate nurse trainingof Mental Health**

**Nurses: Conceptual Model of Good Practice**

**Name of Researcher:** Ray Mbambo

**Please tick box**

6. I confirm that I have read and understand the information sheet dated February 2009, for the above study and have had the opportunity to consider the information and ask questions. ☐
7. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
8. I agree to take part in the above study. ☐
9. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐
10. I agree for this to be audio recorded and for the data to be used for the purpose of this study. ☐

## Appendix 9: Consent and right to withdraw Form

**NB: If you are happy to take part please tick the boxes below and contact your tutor or me to arrange a suitable date for the interviews or group discussions. You can give this form to me when I visit you for the interviews.**

Title of Project: **Cultural care issues in undergraduate nurse training of Mental Health Nurses: Conceptual Model of Good Practice**

**Name of Researcher:** Ray Mbambo

**Please tick box**

11. I confirm that I have read and understand the information sheet dated February 2009, for the above study and have had the opportunity to consider the information and ask questions. ☐
12. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
13. I agree to take part in the above study. ☐
14. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐
15. I agree for this to be audio recorded and for the data to be used for the purpose of this study. ☐



## Appendix 10: Participants Ideas: First Stage – Low level Data Abstraction

**Key:** SL = Senior Lecturer, SN = Student Nurse, SFG = Student Nurse on Focus Group CM = clinical mentor and CSM = Clinical Sign-off Mentor

The numerical number designates which interview, focus group or participant the quote was taken from.

### Senior Lecturer 1 [SL1] – Male – White

*Some available text books tend to talk about cultures in general without any clear guidance in relation to mental health nursing [SL1]*

*We rarely have professional development into diversity training,..... to be more precise here at [Name of University] we attend three hour diversity training once a year as part of the mandatory training [SL1]*

*I'm personally not an expert in cultural diversity; however they are my colleagues who are more competent to teach diversity than I am [SL1]*

*“ ... we don't have specific modules within the pre-registration mental health nurse training as issues of cultural nursing care needs have been incorporated into other modules such as Sociology of Health and Illness where such issues are explored and discussed.....” [SL1]*

*To me culture is a common way of doing, perceiving and reacting to certain stimuli [SL1]*

*“In Birmingham we have got a lot of people from cultural different backgrounds. I sometimes ask my students to do case studies of a culture different from them to find more about their history, origin, faith, religion, values, food, dressing, rituals and so on..... I then ask students to come and present their findings to other students for example if one picks a Moslem culture, I would expect them to say in terms of food, Moslems would only eat Halal meat..... by so doing, the student would at least have some ideas that when they serve food to Moslems, they need to be cultural sensitive to the meat they give them.....”[SL1]*

*As part of my teaching on different nursing care issues including cultural issues, I tend to use case scenarios where students will discuss appropriate responses to a situations and to consider how potential cultural care needs of patients' could be met. [SL1]*

*It sound quite good to invite community leaders to come and talk about their own cultural groups expectation, however, the danger is that the student might view such talks from community leaders as representing their entire cultural memberships [SL1]*

*As lecturers how do we select the appropriate and the willing members of the community to come and deliver such lectures? [SL1]*

*As an introduction or an initial step for students to learn about cultural competence, I would say yes.... it could be helpful to teach students about specific cultures, however, it is important to be aware of the stereotypical views that students can build which could end up being towards cultural incompetence [SL1]*

*Quite a number of students tend to struggle in terms of demonstrating in their assignments on how they provided patient centred care to their clients [SL1]*

*A substantial bit of what I teach involves a lot of consideration of the cultural needs of diverse people and you would find that our libraries are staffed with American and Australian staff which in most cases seemed to be irrelevant here [SL1]*

*I find it better to start by giving students some work whereby they write about their individual and family cultural values, practices and beliefs before the lesson, then come the lesson, I would ask them to bring their anonymous pieces of work forward so that we can read for the whole class. By that I find that students would be able to see where their cultural values differ and are similar to other people [SL1]*

*explore how the learner wants to resolve the situation after providing clear options [SL1]*

*As a lecturer in a culturally diverse classroom, I would prefer the university to fund the courses that will enhance my cultural sensitivity, so that I'll be able shape the curriculum to be culturally responsive to my students [SL1]*

**Senior Lecturer 2 [SL2] – Female – White**

*Most of the research literature available about culture seems to be from other countries such as America Canada, Australia and New Zealand and you would find its applicability a bit vague due to differing cultural histories across continents. [SL2]*

*My last nursing practice job was in the predominantly white British community practice for the last nine years and I think it could be very difficult for me to go into depth teaching students about culture and diversity..... [SL2]*

*“.... We tend to draw up discussion on how the needs of patients form diverse backgrounds could be addressed, however, once in a while you will get students who feel that they are being attacked most of the time because of their cultural affiliations. At times these students would overreact and ended up bringing unsubstantiated accusation to other students. I had one student who openly accused some students of being a racist and ended up accusing me of supporting students to bring racial comments. This is an area which is somehow we had to deal with although err er.er..... especially if the students are all mature students ...” [SL2]*

*“...In addition to experiential learning experience we expose our students to; we specifically ask them to reflect upon their experiences after every clinical placement in a document we give them where they are supposed to link theory to practice. Maybe from this discussion, we might try to be more specific on the objectives of the reflective accounts we expect from students in terms of incorporation of the cultural encounters” [SL2]*

*“..... one of my classes has got more than half students who are non White and majority of them from Africa..... one way I tend to do to reduce racial tensions in class during cultural discussions is to bring statistics and references so that students don't fill intimidated.....” [SL2]*

*We do want to engage everyone who has some expertise, however sometimes it's not that easy as people might think, we have to consider financial resources among other things [SL2]*

*We do want to engage everyone who has some expertise, however sometimes it's not that easy as people might think, we have to consider financial resources among other things [SL2]*

*to listen to the learners, ask learners to name the problem and how they feel about the problem [SL2]*

*We do want to engage everyone who has some expertise, however sometimes it's not that easy as people might think, we have to consider financial resources among other things [SL2]*

*“ not challenging inappropriate behaviour may be seen as colluding behaviour [SL2].*

*Although it sounds more practical to teach students the facts about specific cultures, however, there are risks that students might take those facts and use them to stereotype their diverse client groups [SL2]*

*“.....because cultures do not exist in isolation to the patient, therefore it's very important for our student nurses to look at their patients holistically and that is probably one of the reasons we try to avoid teaching our students separate cultural diversity care modules.....”[SL2]*

*I understand it [cultural competence] as a progressive acquiring of the relevant knowledge and skills of working with diverse cultures [SL2]*

*It's not all of us who are competent to teach diversity, however, if there is need surely we can try and find time to do a bit of research about it...[SL2]*

*I particularly teach my students to be able to move from being culturally aware of their own heritage to becoming culturally aware of the heritage of others [SL2]*

*If we involve ex service user to come and deliver the lesson, we also as lecturers learn from them and devise future guidelines on what to teach based on their needs. [SL2]*

*there is no definite way to challenge inappropriate behaviour and that each nurse educator would find his or her own approach to challenging effectively [SL2]*

*it can be seen as colluding behaviour [SL2]*

### **Senior Lecturer 3 [SL3] –Female – Non White**

*We do have some text books stuffed in or libraries but many of them are superficial and lack that detail [SL3]*

*Of course as educators we supposed to do some research about the topic ourselves..... if the topic is a requirement..... it's not simply enough to say we're not taught in our training..... however, we can only teach what we are confident in [SL3]*

*“.....although we are including cultural competence in our current curricula, I think as nurse educators we probably need to do more than what we are doing now .....I strongly believe that integrating cross cultural education into the training of nurses may improve nurse patient interactions among the marginalized patients and there is a lot of research to support me.....” [SL3]*

*“..... In one of our Domains of Nursing module we give student scenarios of patients from different backgrounds to research on their nursing care needs and then they choose the scenario and prepare it for the viva presentation.....”[SL3]*

*“ .... I don't agree and believe that any lecturer can teach any student to become cultural competent..... secondly as cultures do not exist in vacuum, therefore cultural competent cannot be taught as a set of unchangeable facts.....cultures change with time, preferences.....societal expectations, .....even politics or the legal system of the country can force certain cultures to change their traditional habits such as arranged marriages in*

*Western societies for example.....”[SL3]*

*“.....it’s about the content and the direction of lesson that cause racial disruptions.....  
Once you give ground rules in your class, there is unlikely to be any racial  
disruptions.....” [SL3]*

*Although it sounds a good idea to invite the community leaders, however, there is always that  
danger ..... that possibility that some members of the community might not appreciate the  
potential benefit of consultation and might not be willing to be consulted [SL3]*

*..... you would rarely find any discussions in mental health nursing that doesn’t  
acknowledge the diversity of individuals [SL3].*

*I have come across in many instances where students view a culture as a homogeneous  
system shared by members of the society and therefore expect it to be something that can be  
separated and distinguished from other cultures. This is however not the case, cultures to me  
are quite dynamic and students need to be taught that is not the case [SL3]*

*My understanding of cultural competence is the developing of the required standards of  
working with diverse communities in a way which recognises and respect individual  
differences [SL3]*

*Of cause we have access to interlibrary loans which one can possibly use if he or she is  
lucky, however, such books or materials can take up to two weeks to arrive from wherever  
they come from, however students don’t have such access and the budgets are tight...[SL3]*

*Whilst it’s the right thing to encourage students to reflect on their self, it is equally true for  
educators to reflect on their own personal biases about some cultures [SL3]*

*At one time I asked students to tick their cultural background in terms of ethnicity and there  
were some White students who ticked to say that they had no ethnicity or culture [SL3]*

*What is important as a lecturer is to be able to deal with such tensions effectively. One way I  
will deal with such tensions myself is possibly to approach cultural awareness programs from*

*both the advantages of the privileges enjoyed by White dominant groups and the disadvantages suffered by ethnic minority groups. By so doing, perhaps the privileged dominant members of the group might appreciate other people's disadvantages and may avoid negative attitudes to them. [SL3]*

*".... there is no better way to develop understanding of a culture than to live within it". [SL3].*

*Well, time and again as a mental health lecturer you should expect to find some tensions among diverse groups of students during discussions centered on cultural diversity due to student cultural uniqueness. What is important as a lecturer is to be able to deal with such tensions effectively. One way I will deal with such tensions myself is possibly to approach cultural awareness programs from both the advantages of the privileges enjoyed by White dominant groups and the disadvantages suffered by ethnic minority groups. By so doing, perhaps the privileged dominant members of the group might appreciate other people's disadvantages and may avoid negative attitudes to them. [SL3]*

*I think students' self esteem and moral can be boosted by culturally responsive curriculum [SL3].*

**Senior Lecturer 4 [SL4] – Male – White**

*..if people can do their maths right, of course they will determine the proportion amount of time to be spent addressing diversity within the curriculum. I am not denying that people's needs should be ignored, but issues of culture have been blown out of proportion .... [SL4]*

*.....If people want to base on statistics, then they I think we are doing much more in terms of addressing the care needs of foreigners and other non White British people. Whether you want to say the last census gave the population of the ethnic minority to be 6% or 10%, then I think we are putting more than 10% effort in trying to address the care needs of these ethnic minority people ..... these reports such as the Bennett Inquiry they say what their authors wanted to say ....[SL4]*

*Most books are biased on certain cultures and relying on them will be a myth considering acculturation [SL4]*

*of course I really appreciate and understand the concerns in your research, probably from experience and encounters you or your colleagues, relatives friends might have had a bad experience from the care given by nurses, however, realistically, we're doing what we're doing within the best of our abilities to try to address the issues of diversity within our teaching, however, there's also a question of whether we ourselves are competent to deliver the expectations ..... I mean whether our system has the necessary support for lecturers to deliver this [SL4]*

*"... to me there is no wrong or right approach. Both experimental learning and traditional based classroom training when it comes to training students to nurse diverse people are all ok. I think each complement another. However, my personal opinion is to have students experience interacting with different backgrounds during their clinical placements then they come back to class for reinforcement on what they learnt. At the same time our students are adults and they are more likely to research or ask certain elements of cultural care in class especially those issues that gave them trouble at placements. Think it this way, although not impossible, it is very hard to theoretically teach somebody to repair a computer when they have never seen one" [SL4]*



*“I personally disagree with those who say the curricula doesn’t address the care needs of diverse patients, the truth is that there is a lot within the curriculum about non discrimination practice from the national Service Framework of Mental Health to the NMC code practice... what I foresee as the only weakness is that currently they’re very few ways of formally assessing student competence and as a result, some student don’t take it serious” [SL4]*

*Cultures are not static and I see no much benefit in engaging community leaders to be part of our team [SL4]*

*I don’t agree with those who say that we should teach students about specific cultures or cultural norms. First cultures aren’t homogeneous and therefore people don’t have to make assumptions..... Secondly, culture they aren’t any specific cultural norms because culture aren’t static but are very dynamic and acculturation is always influencing people’s beliefs [SL4]*

*Cultural competence is an ongoing learning and acquiring of skills and specific competences about working with cultures and their acculturations and it’s not something that can be validated by being put into a specific two week course or passing an assignment or test [SL4]*

*Cultural competence is an ongoing learning and acquiring of skills and specific competences about working with cultures and their acculturations and it’s not something that can be validated by being put into a specific two week course or passing an assignment or test [SL4]*

*People need to be careful on what they read and teach students, because there’s a lot of misleading and stereotypic information out there [SL4]*

*“.... Of course we can try to openly address issues of White privileges and the disadvantages faced by some racial minority groups in this country when teaching cultural competence, however, they are possible dangers that we might over-generalise or reinforce stereotypes about particular cultural groups considering issues of Al-Qaida and some cultural groups...” [SL4].*

**Senior Lecturer 5 [SL5] - Female - White**

*It depends with each individual lecturer's comfort in teaching certain cultural topics [SL5]  
Because not all lecturers are comfortable at teaching cultural diversity training, at this university we're composed of diverse lecturers and one of the lecturer involved is from XXXX [a named African country given][SL5]*

*Not sure of any guidelines [SL5]*

*" ..... when I am addressing issues of culture and its impact on mental health I find it helpful to put students in let's say two groups to research about particular topics then invite the groups to do some intergroup dialogue about their findings which I find my diverse student groups welcoming such discussions well...."[SL5]*

*".....I'm not quite sure but I would suggest that any lecturer who wants to introduce sensitive topics on culture and its impact on mental health nursing, I think they should possibly introduce the topic with some epidemiological data and statistics including their proper references so that listeners could see that it's not the lecturer's opinion data and there is no stereotyping.... In this way, possibly the students could possibly develop be open minded attitudes". [SL5]*

*I also employ case scenarios which I find useful when it comes to transfer theory into practice [SL5]*

*I sometimes ask students from different backgrounds to come and role play the nurse-patient interaction which I believe is one of the ways we train our students some skills of cultural competence [SL5]*

*Although it might helpful to consult or ask senior community leaders to come and help us deliver, however, one has to realise that in practice, it might be difficult to consult those community leaders and also demands time [SL5]*

*Quite a number of students tend to struggle in terms of demonstrating in their assignments on how they provided patient centred care to their clients [SL5]*

*“One of the issues we tend to focus on when teaching students to nurse diverse patient groups is to be patient focused rather than focussing on the patient’s cultural background..... If the students put their focus on the client’s needs, then automatically the issues of culture will emerge automatically and they can take on board holistically and not in isolation..... However, if the student put more emphasis on the patient’s culture, the nursing care outcome is mostly likely to be influenced by cultural prejudices... .”[SL5]*

*“....lecturers are different and each one is free to have their own approaches. My own approach when addressing the nursing care needs of diverse patients is by using the patient centred focus approach. By using the patient focus I will be able to teach my students ways of viewing the patient as a whole rather than their cultural backgrounds or their illnesses. By taking such a holistic view of the patient, then automatically the patient is empowered to discuss their own illnesses as they experience them..... obviously in turn, the patient would be able to give a clues to the nurses about their cultural beliefs and how such cultural beliefs influences or have an impact on their health”[SL5]*

*Cultural competence is those skills and attitude required by a competent nurse to work with different cultures [SL5]*

*A lot of textbooks you find in our libraries provide insufficient information that has the potential of leading us to teach stereotypical views of some cultures [SL5]*

*If anyone or yourself can come up with good guidelines for us to use, I think it will be great and make our lives easier [SL5]*

*One of the strategies I tend to use when addressing issues of culture in class is to ask students to consider their own cultural backgrounds and practices before attempting to teach them about other cultures [SL5]*

*knowing what to challenge, and when to challenge, can be tricky and open to personal interpretation [SL5]*

*By inviting members of different communities to come and deliver lessons, students will be*

*able to see how different cultures within the communities view mental health issues [SL5].*

**Senior Lecturer 6 [SL6] - Male – Non White**

*We are all supposed to include it in most of the topics we deliver as they tend to involve culture, however, I can not say for individual lecturers [SL6]*

*“.....definitely culture has a lot of impact on mental health, for example, in nursing, the NMC requires students to provide choice to the clients.....therefore, students need to know that in order to provide greater choice and satisfaction to patients, they need to be aware of the patient’s beliefs, values and desires..... which in most cases are culturally formulated...” [SL6]*

*“ ...our roles are not to make judgments about whether racism may or may not be taking place... “ [SL6].*

*“ .... Yes from the layman’s point of view it might be seen as an important thing to have specific modules on cross cultural nursing care, but, who knows, whether students will take that module as an add on extra burden to what they learn, or a separate entity which should be applied separately is something to be considered. .... “[SL6]*

*“I sometimes give my students scenarios for example, one of the scenarios I gave them was of an Afro Caribbean young man who was experiencing signs of schizophrenia living with parents who were dedicated Christians..... I asked learners to identify possible causes of his illness, and possible nursing interventions ..... Obviously I would expect the students to link the attributes of somebody from an Afro Caribbean background on their discussions from assessments to interventions..... ” [SL6]*

*“ ....when things go wrong in mental health nursing practice, the government and the public witch hunt into the training institutions just like what happens with Stephen Lawrence and \rocky Bennett..... ” [SL6]*

*We have in the past invited nursing practitioners from diverse backgrounds to come and*

*teach their areas of expertise and we will continue to engage cultural competence experts if our budgets allows [SL6]*

*roles were not to make judgments about whether racism may or may not be taking place [SL6]*

*I find it very strange and impracticable to teach students about what they perceive as the common cultures around even Birmingham. Just one individual client can have more cultural influences that might need to be addressed and that it may be impossible for any lecturer to teach about the particularities of all the different cultural groups found in Birmingham alone yet in the UK [SL6]*

*It's recognising the differences in cultures and act accordingly to those differences in a respectful way [SL6]*

*I have come across a peer reviewed article with inaccurate information about my own culture, and how can I use such an article as a reference or guideline to teach about cultural needs of patients who share the same background as me? [SL6]*

*If people are able to reflect on their personal values and biases, obviously they will be able to understand and appreciate other people's cultural values and beliefs which are different from them [SL6]*

*Yes, there is a possibility that it [cultural competence] could be left out if there are no guidelines to assist educators when designing the nursing modules [SL6]*

*Knowing the cultural background of my students and developing my cultural sensitivity through attending relevant professional development courses in cultural diversity will be a crucial part of teaching in the classroom [SL6]*

*These community members and service users are not the source of cultural competence knowledge and skills, but, rather, are partners in planning for their communities' general needs. [SL6].*

**Senior Lecturer 7 [SL7] – Female - White**

*To effectively teach cultural diversity, I think lecturers also need strong institutional support and some professional development in that particular area of which I believe at present it's not that enough [SL7]*

*"..... whilst I don't deny the possibility that the current nursing curriculum might need to be strengthened in terms of incorporating the cultural diversity teaching, however, at the same time I don't agree on the one size fits all approach. [SL7]*

*.....Individual lecturers should still have the autonomy on what to include in the curriculum and how they prefer to deliver such teaching .... Remember teaching depends on what individual lecturers feel comfortable with. You once mentioned to me that during your research some lecturers felt uncomfortable to control escalating outbursts that arose from students during discussion of cultural issues. How then would you expect them to manage the situation if things are to be forced on to them....."[SL7]*

*Culture is the way of valuing life which is dependent on the place of origin and the sphere of influence [SL7]*

*" .....there are many ways the students can gain knowledge, however in nursing one of the most recognised ways of imparting knowledge and skills to nursing students is through exposing nursing students to situations where you want them to learn so that they can gain that personal experience to the environment -- some say experience is the greatest teacher .... When it comes to culture and diversity, at this university we do not necessarily have modules specifically on culture and diversity as our student possibly learn those things at their placement settings ..... However, I should think the nursing care needs of diverse patients as you have specifically asked are possibly addressed within other modules but I am not 100% sure because I don't know what other lecturers do in their teaching." [SL7]*

*can be challenged by not punishing or blaming the learner, but by understanding your learners and suggesting a better way of saying things [SL7]*

*“to me I believe experiential learning to be one of the highly effective educational methods of equipping our student nurses especially when it comes to gaining the pre-requisite cultural competence knowledge. People must remember that no one can be said to be cultural competent in each and every culture as cultures are dynamic. If our students go on placements, they meet and interact with different cultures at more personal levels and possibly gain more that way rather than relying on teaching centered on culture alone”*  
[SL7]

*I don’t think that the idea of inviting community leaders and other members of the local community to come time and again to deliver cultural diversity to nursing students as a good idea especially within this university considering the current budget constraints [SN7]*

*preparing students to be cultural competent is not about teaching students about specific cultural groups which to my opinion those specific groups don’t exist [SL7]*

*There are good and bad guidelines on teaching cultural diversity, the main challenge I think lecturers face is to find good guidelines as they only appear to be few of them [SL7]*

*Some of the mentioned tensions could be reduced if students are encouraged to express their own individual personal values and beliefs first in order to appreciate other people’s values and beliefs [SL7]*

*Some of the mentioned tensions could be reduced if students are encouraged to express their own individual personal values and beliefs first in order to appreciate other people’s values and beliefs [SL7]*

*“ ...To minimise such racial tensions in class, I think Lecturers are supposed to make sure that the curriculum materials, textbooks and other resources used in classrooms should clearly produce meaning and define what’s appropriate in promoting social relations among diverse student groups” [SL7].*

*“Within this university, we tend to invite a lot of ex service users’ and interested members of the community or practice nurses to come as guest lecturers and some are also responsible for identifying and providing support for lecturers when addressing issues of cultural competence within the curriculum” [SL7].*

**Senior Lecturer 8 [SL8] – Male – Non White**

*Depending with the student group make up, some topics are not worth pursuing if they tend to bring such tensions you have mentioned to me.....I can remember a couple of times when I had to technically change the discussion when I noticed some discomfort in certain students[SL8]*

*It would be helpful if we had some sort of guidelines on what to include in the curricula [SL8]*

*“ ... nursing is a more practical field as opposed to being theoretical ..... You can read a very good book about flying an aeroplane but before somebody takes you to the pilot’s cork to practically do it you will not be able to fly it. That’s exactly what nursing is. If students are sent to clinical placements and work with people from diverse cultural backgrounds, they are more likely to learn more from observing and interacting with them rather than giving them notes alone about different cultures. .... I do support the traditional based classroom teaching, however, but in nursing some aspects cannot benefit from the classroom teaching setting, and I think cultural competence is one of them ..... therefore sending the students for clinical placement to feel how those different cultures expect the nurses to treat them I think will be more beneficiary” [SL8]*

*nurse educators will at times be required to challenge learners over some of their behaviours that they feel could be potentially discriminatory [SL8]*

*Due to our focused budgets and time it’s not always possible to invite community leaders to come and teach students about cultures in general as they’re themselves not experts in cultures in general with probably the exceptions of their own cultures.....[SL8]*

*I would say in each and every module studied, students are taught the different skills of communicating with different patient groups which includes the deaf, those whose first language is not English or where clashes of accent co exist... [SL8]*

*“Within our roles as nurse educators, we will at times be required to challenge learners over their behaviours that we feel are potentially discriminatory....” [SL8].*



*It is important that we equip student nurses with the skills of discussing any treatment plans with the clients and then negotiate the plans of care with clients and their families or carers [SL8]*

*Sometimes the lecturers might have the interest to research more about cultural issues they would want to teach, but sometimes it's hindered by the lack of readily available teaching resources within the university..... [SL8]*

*If students are equipped with the skills of self awareness, they will be able to understand and appreciate the cultural differences and similarities that exist within, among and between groups [SL8]*

*Nine out of ten you find that students are spitted according to their cultural pockets which makes it harder at times for students to cross share their cultural heritage [SL8]*

*“..... when I brought in and presented some statistics and materials about certain culture you could tell that some students felt as if their cultures are being attacked....” [SL8]*

*I think the curriculum is already over stretched and that adding more courses is of no great benefit [SL8]*

*As lecturers, I think it is very wrong for us try to engage ourselves into these political debates where we view cultural diversity narrowly as ethnic customs and immigrant religious beliefs...[SL8]*

**Senior Lecturer 9 [SL9] – Female - White**

*“..... although I don’t believe that we can teach our nursing students to become cultural competence practitioners, however, I strongly believe that if we can sought out and engage such cultural experts like Dxxxxxx Sxxxxxxx [named professor and expert in cultural competence], our student could possibly gain much more than from most of the lecturers like myself who are nine out of ten not really competent in the subject.....” [SN9]*

*Many text books have for decades now talked about the inequalities in health and the impact such inequalities have on minority patients and I don’t think this could be the solution.....I think educators should start openly and explicitly discuss with their students the advantages that majority White people enjoy in society rather than solely focusing their discussions on the disadvantages faced by minority groups in this country [SL9]*

*I personally feel that as senior lecturers we are ill equipped to teach cultural sensitive topics and issues related to anti discriminatory practice in mental health [SL9]*

*I would introduce literature including equitable representations of diversity through the use of educational materials that are culturally sensitive to my diverse student groups [SL9].*

*as well as taking any supportive actions that may be required [SL9]*

**Student Nurse 1 [SN1] - Female – Non White**

*With only a few lessons centered on cultural nursing, it's hard to say with certainty that our own training prepared us enough to nurse diverse cultural groups....[SN1]*

*“In my opinion, I think that integrating and incorporating the concepts of cross cultural nursing care into other modules already present during our teaching may be an effective way of highlighting the importance of cross cultural nursing care considerations not just as an add one extra burden but as an essential component of the holistic patient care.....”[SN1]*

*“..... Although it was challenging during the process of learning about cultural diversity due to tensions in class, overall I found those few lessons beneficiary although not enough to say I am well prepared to be released and effectively work with cultural diverse patients.....”[SN1]*

*“ .... The minute I mentioned that some cultural norms that nurses are expected to respect seem to be too primitive..... , some students in class started to Bu u u u me before I finished what I wanted to say..... Some students openly started accusing me saying do you think your own culture is a more civilised than the rest..... Some started accusing me of making some racial comments when in fact I did not make any racial comments at all..... Our class tutor who is also White just stood up and waited till the arguments were tense between Black students and white student in class. The only thing he said was that the argument was out of proportion and we need to change topics. The atmosphere in class was as if there was a civil war between black students and White students ....” [SN1]*

*“ .....the assumptions they teach us about certain cultural groups is not helpful at all....” [SN1]*

*Some of the patients when they develop mental health problems, they will loose their ability to speak in English and therefore would need interpreters [SN1]*

*We learnt much about being culturally sensitive when interacting with community members who were involved in the delivery of the curriculum. [SN1].*

**Student Nurse 2 [SN2] – Male – Non White**

*Only now in our third year, I can remember having ex clients and ex carers coming to talk about their experience of the nursing care they received from the mental health staff and how they preferred to be cared... it could have been more beneficiary if we had more of these training from our first year...[SN2]*

*Some of our lecturers seemed to pick and choose the topics which they think will be liked by students... if topics that bring tension in class arose, the lecturers will divert to another topic....[SN2]*

*I know it's difficult to teach us about the care needs of everyone, however, they must teach us about the basic cultural needs of the major cultural groups around us [SN2]*

*I think communication is one of the important care needs of patients from different cultural backgrounds [SN2]*

*It's unfair when lectures give summary statements about the cultural beliefs of Africans as if Africa is a single country [SN2]*

**Student Nurse 3 [SN3] - Male – Non White**

*It's simply a cut on the edge [lessons on cultural nursing care], so long as if it's covered, some aspects such as providing an interpreter are not fully discussed...[SN3]*

*It could be a better idea if we can have modules specifically dedicated to cultural diversity like what we have in other modules [SN3]*

*".... Because of the few lessons we had during our second year and a few lessons conducted by external speakers on diversity, I think I have at least grasped something. ....I feel much more confident now to nurse people who's cultural backgrounds are different from mine..... "[SN3]*

*If I were a lecturer, I would teach students information about specific cultures within the UK [SN3]*

*As nurses we need to carefully listen to the accents of the patients and we also need to talk slowly and loudly especially if we have got different accent from them [SN3]*

*It gets deep into my nerves if lecturers time and again refer to Asians and Moslems when they give examples of cultures as if they're the only cultures on earth [SN3]*

*'..... at one time our lecturer gave an example of an Asian woman who died in a temple fire and some students began questioning why the lady didn't run away gazing at me as if I was the one with her in the temple...' [SN3]*

*" .... Issues of culture are covered a lot throughout the undergraduate curriculum but not in a meaningful depth to distinguish stages of progression....." [SN3]*

*We have learnt and gained as much as possible about some of the community members' culture from the ex service users who participated in some of the lectures [SN3]*

**Student Nurse 4 [SN4] – Female – White**

*If it's that important they would give us assignment or test to assess us..... so why bother for extra burden that does not look like part of the requirements to achieve the nurse training....." [SN4]*

*".... It's clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn't important. If It's that important they would give us assignment or test to assess us..... so why bother for extra burden that does not look like part of the requirements to achieve the nurse training....." [SN4]*

*.... It's clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn't important.. [S4]*

*" ..... we had lessons in sociology of health and illness where we learnt about inequalities in health in terms of class structure, ethnicity, social class, races and so on....." [SN4]*

*If I were a senior lecturer, I would do more in terms of teaching the nursing care needs of diverse patients as at the moment I feel its not enough [SN4]*

**Student Nurse 5 [SN5] – Female Non White**

*..... I think as nursing students we have more important modules that are formally assessed to worry about than spending our precious time debating and racially accusing one another ..... just because other people think there cultures are more superior than others. [SN5]*

*“ ... my previous clinical placement had patients from different ethnic, racial and cultural backgrounds and I gained a lot of skills and knowledge from them during our interactions....” [SN5].*

*In nursing if you're not sure you need to ask, therefore, if our lecturers are not sure or confident of addressing some of the cultural care needs of diverse patients they also need to ask those local people to come and give us a talk [SN5]*

*I was upset to hear our lecturer repeatedly saying “White indigenous population” as if they're no black indigenous populations [SN5]*

*I was upset to hear our lecturer repeatedly saying “White indigenous population” as if they're no black indigenous populations [SN5]*

*Majority of the time the books and materials recommended by our lecturers are dominated by information that support the supremacy of the western cultures as number one [SN5]*

**Student Nurse 6 [SN6] – Male – Non White**

*“Students and nurses need to know how cultures shape every aspect of the nursing process up to the extent of planning appropriate services for patients during discharge..... This reminds me of one illiterate client who was from Somali origin. As part of the discharge aftercare the nurse suggested that the social worker access funding for the client to attend local Bingos to minimize loneliness. I happen to know the local Bingo club in question which was used by predominantly White elderly people....” [SN6]*

*Some lecturers try very hard, of course we don't expect them to know it all in details, there are so many of them[cultures] and some of those cultures prefer the aspects of their cultures to remain private to them..[SN6]*

*“I think that our lecturers are actually promoting prejudice by asking us to do case studies of especially the Asian and Afro-Caribbean cultures and to come and present them in class discussion.....” [SN6]*

*“I found most of the reference materials recommended by our lecturers to be biased towards the Western cultures. You rarely find such reference materials acknowledging or appreciating the benefits brought to this country by foreigners ..... I wish if our lecturers develop a big picture when recommending us further reading materials which at list demonstrate some of the good things done by diverse cultures in this country...” [SN6]*



**Student Nurse 7 [SN7] – Female White**

*...if you go to Rome, you are expected to do what in Rome the Romans do, but why is it that that when people come to Britain, they expect the British to be experts in those foreign cultures? ... [SN7]*

*“..... after all why should the lecturers waste their time and our time teaching on how to provide excellent nursing care to strangers..... We didn't come to the university to learn about providing excellent nursing care to foreigners .....” [SN7]*

*“....even some of our lecturers when they teach about diversity, you can tell that they aren't comfortable with some discussions [SN7]*

*Why not invite some good spiritual leaders and pastors from the local communities, at least they can make a difference and after all they are used to teaching big crowds [SN7]*

*“ ...To minimise such racial tensions in class, I think Lecturers are supposed to make sure that the curriculum materials, textbooks and other resources used in classrooms should clearly produce meaning and define what's appropriate in promoting social relations among diverse student groups” [SL7].*

**Clinical Mentor 1 [CM1] – Female - White**

*“I think a curriculum that has meaning in terms of addressing the needs of diverse communities has to connect and engage the support of people from those diverse cultural groups, for instance at least engaging or involving respective community leaders as they are in much more position to define some of the community needs.....” [CM1]*

*I think I would teach learners about the major specific cultures that are mostly found on the placement settings such as Moslems, Afro Caribbean, and Sikhs and so on [CM1]*

*I have come across many of my students who are very good communicators but when it comes to work with clients, they cannot develop proper rapport with clients... I think this is a skill which probably needs to be addressed with the classroom setting by their lecturers [CM1]*

*Some of our clients came from far places such as Kosovo and without any clinical history at all ..... Some student nurses tend to struggle when it comes to client history taking; therefore I think it might be helpful if their training also prepares them more when it comes to interviewing clients especially for the first time. ... [CM1]*

*“.... From working with nursing students in a cultural diverse place like H\*\*\*\*\*, to me patient centred care is the key to cultural sensitive care, hence strategies to teaching patient centred care must be a must in the curriculum if students are to be equipped with cultural sensitive nursing care skills.....” [CM1]*

*I think one way to tackle the issue of culture within the university setting is to encourage students to reflect and examine their own cultural values and beliefs first in order to appreciate the cultural values and beliefs of others [CM1]*

**Clinical Mentor 2 [CM2] – Male – Non White**

*....I don't remember us doing much during our time, however, I have attended a lot of diversity courses in practice..... [CM 2]*

*“ ...the cultural nursing care needs of patients from diverse backgrounds can be integrated into the core curriculum by a number of ways ..... such as having case scenarios which specifically demands the knowledge and skills of diversity..... For example, one might give students case scenarios in which cultural difference acts as an obstacle to the assessment, planning and implementation of a programme of care. Such case scenarios have ability to develop a participatory decision making style on students to how issues of culture impact the whole care delivery.....”. [CM2]*

*Mental health nurses need to be trained on how to negotiate with the clients all the care planned and implemented [CM2]*

*“..... I think lecturers have to step their efforts and try to teach students better skills of providing holistic patient centred care to their clients. To me each patient is diverse and has his or her own worldviews about a particular condition or illness and such world views could be influenced by their social environment or religious beliefs.....” [CM2]*

*Nurses must be trained at least to understand the artistic expressions of major client groups they serve [CM2]*

*I think lecturers must include in their teaching the various positive contributions made by people from different parts of the world to this country [CM2]*

*“ ..... I can recall my first days as a newly qualified nurse that I felt ill equipped to challenge the expression of racist sentiments in practice settings because during my nurse training we were never taught to deal with racism in practice .....” [CM2]*

**Sign off Mentor 1 [CSM1] – Female – Non White**

*“.....the senior lecturers at the universities need to incorporate within their core modules issues of culture and mental health nursing. They also need to teach the nursing students about culture and its impact on them and the communities they will save. For instance, if the communities they will save are mainly composed of Moslems, at least they need to teach basic Moslem mental health nursing care needs...” [CSM1]*

*“ .... There are no specificities student should be taught about cultures; however, if they can be taught about the common cultural expectations from different cultural groups, I think this will be enough. There is evidence from speaking to some of my students that at least they were taught about providing cultural sensitive nursing care, however, there is also a suggestion that some students were not exposed to such teaching at all. Probably the multicultural teaching is done; however, I don't think it's done across the board. All students need to be exposed to it. During my nurse training, I don't remember receiving such training at the University....” [CSM1]*

*instead of always seeking out and engaging only those with PhDs and masters to come as visiting lecturers as they used to do during our training, I would recommend if the universities can now take it as an opportunity to involve the less academic ones such as community leaders to come and address the mental health care needs of their communities [CSM1]*

*Community leaders hold the influence of making their followers engage or disengage with the services..... having the knowledge that nurses are also being trained by community leaders could have an impact on how services are perceived by the public.....” [CSM1]*

*I would teach student about cultural diversity and how to respect the cultural differences is I was one of the lecturers [CSM1]*

*I have come across some third year mental health nurses who aren't aware that the care plans should be a result of a partnership in decision making between the nurse and the patient [CSM1]*

*“No matter whatever cultural background the patient comes from, the patient must be the judge to their own care..... within the curricula, I think students need to be taught different ways of empowering patients to negotiate and decide their own nursing care.....” [CSM1]*

**Sign off Mentor2 [CSM2] – Male -White**

*“..... one way the university can do is to have some budget for external visiting people such as community leaders and other cultural experts to come and give a talk to students about their cultures, their expectations when members of their families are unwell, and how they preferred the nursing staff to provide nursing care to those family members. .... this is possible although might not fit well with some of the budgets.....” [CSM2]*

*in order to ensure that they create a learning environment that is free of discrimination and that values differences [CSM2]*

*It won't make any difference to me to teach students about specific cultures .....Even in the very unusually small cultural groups; there is great diversity among individuals [CSM2]*

*“when planning and implementing any nursing interventions, students are supposed to know that the centre of the focus is the patient and their immediate family.....this is because the patient and their family are in a better position to identify and understand their cultural beliefs and influences that affect their mental health and recovery.....” [CSM2]*

*“having a community member and or the mental health service user, working and interacting with the students as part of the guest lecturer provides nursing students with an increased opportunity to learn more about the cultural nursing care needs of those represented.” [CSM2].*

*The mental health nurse curriculum should include content about the cultures and contributions of many ethnic groups to the society using a variety of teaching techniques that are culturally responsive to different ethnic learning styles within the classroom environment [CSM2]*

*The mental health nurse curriculum should include content about the cultures and contributions of many ethnic groups to the society using a variety of teaching techniques that are culturally responsive to different ethnic learning styles within the classroom environment [CSM2]*

*Although I have signed off student as competent, but I could tell that majority of the third year student nurses I have mentored lacked the understanding of the implications of cultural diversity in practice ..... and I can't penalise them for issues that they claimed to have not been taught at college..... [CSM2]*

**Student 1 Focus Group 1 [S1FG1] – Female – Non White**

*“.... It was during our second week at uni [university] when our Sociology in Health lecturer came in class and he started introducing the sociological aspects of mental health topic. The moment he mentioned that some cultures tolerate mental health differently; many students looked at me as if I was the culture being referred to .... And I felt necked..... ”[S1FG1]*

**Student 2 Focus Group 1 [S2FG1] – Female – non White**

*..... As an Asian student, every time we have lecturers that involves cultures, I hate it, .....especially when one of the lecturers mentioned that he hopes the discussion would not offend anybody again looking direct into my face as If I was the only person who got offended.....[S2FG1]*

*“... those clients from different cultural groups who came to give the talks to students made us more aware of their diverse expectations and that each is different and there is no need of knowing it all as we will ask them in practice and they will tell us.....” [S2FG1]*

*“ ..... when people start discussing about cultural care needs of patients, they tend to look at me as if I am an expert of cultures. Being born by Asian parents does not make me an expert in Asian Culture. I hate it. I hate ..... because people don't stop it. I remember when we were talking about different approaches to death and how nurses should respond..... the moment the tutor asked about what happens with the Sikh..... , all eyes were on me as if I was a Sikh myself.....”[S2FG1]*

**Student 3 Focus Group 1 [S3FG1] – Female – White**

*“ .... Before these patients come to Britain, they were at least supposed to think of what could be the consequences when they become ill. Obviously we're not expected to know their single cultural norms in order to be good nurses. People who want to come to England need to know that they are going to England where English people speak English and nurses are not expected to learn their vernacular languages just for the case of trying to nurse them. .... in my opinion, I think issues of language barriers should not be a burden for the nurses and nursing students, but for the patients' families... that is if they wish their own relative to be treated by British Nurses ....” [S3FG1]*

**Student 1 Focus Group 2 [S1FG2] - Female – Non White**

*If they aren't prepared to provide proper care to them, so why invite them in the first place*  
[S1FG2]

*"Learning the same issues every time throughout the three years becomes boring and is not helpful"* [S1FG2]

*".... To say we didn't cover issues of culture and diversity, I'll be lying, and again to say we really covered such issues, I'll be vague. The truth is that lessons on culture and diversity were introduced, then run over in a couple of minutes then moved on to the next topics....."*  
[S1FG2]

*Some clients just want to be listened to so nurses should have skills of good listening without interruptions* [S1FG2]

**Student 2 Focus Group 2 [S2FG2] - Female – Non White**

*"..... Yes X is right, our lecturer just whitewashed issues of culture and asked us to research more without telling us whether feedback was needed from us or not.....to me it was like as long as they are covered..... from such an approach it's difficult for me to give a definite answer to say I'm prepared from such lessons we had on cultures because I didn't do it and nobody asked me why...."* [S2FG2]



**Student 3 Focus Group 2 [S3FG2] – Male – White**

*“Some of these people [ethnic minority] it’s not their choice to be here, they were forced... circumstances drove them to loose their identity, let’s not forget the days of slavery, slavery is over and let’s give them the care they deserve.....” [S3FG2]*

*“ .....from few of the lessons we had in class and some talking from the externals such as ex-patients and carers, at least I’m a bit confident of the expectations when I go into practice after summer..... ” [S3FG2]*

*“ .... When discussing issues of culture in classroom environment, our lecturers always gave the same or similar examples in each and every lesson” [S3FG2]*

*Birmingham is such a diverse city, however, why can’t they teach us about the major cultures and ask us to research about the rest [S3FG2]*

*Some cultures if interrupted when they are talking during interviewing them, they become upset or aggressive, therefore you need to listen to them inventively [S3FG2]*

**Student 4 Focus Group 2 [S4FG2] - Female – Non White**

*“it’s pathetic to hear that some people still feel that certain members of the British society don’t belong to the British society and the have to do what in Britain the British do [responding to ‘what the Romans do’] XXX needs to know that even the Caribbean is not their home, they were just dumped there..... remember they came to the plantations packed like bundles of wood in a basket..... Otherwise their mental distress is caused by their disturbed minds about their forgotten identity and roots ..... so we need to give them a thousand percent care” [S4FG2]*

*Even if the lecturers decide to pick and choose let say some of the cultural groups within the UK society, still they can find themselves discriminating those minor groups that will be left out.... [S4FG2]*

<b>Student 5 Focus Group 2 [S5FG2] - Female – Non White</b>
<i>Of course the world has probably millions of cultures, but why not teach us about those common ones [S5FG2]</i>

<b>Student 6 Focus Group 2 [S6FG2] – Male - White</b>
<i>..... we didn't come here [to the university] to spent majority of our time learning about providing excellent nursing care to foreigners only ..... if we spent such a substantial amount of time learning about their needs, how much time are we supposed to spend learning about the indigenous White British people who are the majority? ..... [S6FG2]</i>

## Appendix 11: Clustering Repeating ideas into Themes: Stage 2: Middle Level Data Abstraction

### Theme 1: Issues of culture are inadequately or marginally incorporated in curricula

*“Most of the research literature available about culture seems to be from other countries such as America Canada, Australia and New Zealand and you would find its applicability a bit vague due to differing cultural histories across continents.” [SL2]*

*“Some available text books tend to talk about cultures in general without any clear guidance in relation to mental health nursing” [SL1]*

*“We do have some text books stuffed in or libraries but many of them are superficial and lack that detail” [SL3]*

*“Some available text books tend to talk about cultures in general without any clear guidance in relation to mental health nursing” [SL1]*

*“Most books are biased on certain cultures and relying on them will be a myth considering acculturation” [SL4]*

*“It depends with each individual lecturer’s comfort in teaching certain cultural topics” [SL5]*

*“We are all supposed to include it in most of the topics we deliver as they tend to involve culture, however, I can’t say for individual lecturers” [SL6]*

*“To effectively teach cultural diversity, I think lecturers also need strong institutional support and some professional development in that particular area of which I believe at present it’s not that enough” [SL7]*

*“I personally feel that as senior lecturers we are ill equipped to teach cultural sensitive topics and issues related to anti discriminatory practice in mental health” [SL9]*

*“We rarely have professional development into diversity training,..... to be more precise here at [Name of University] we attend three hour diversity training once a year as part of the mandatory training” [SL1]*

*“My last nursing practice job was in the predominantly white British community practice for the last nine years and I think it could be very difficult for me to go into depth teaching students about culture and diversity....” [SL2]*

*“Depending with the student group make up, some topics are not worth pursuing if they tend to bring such tensions you have mentioned to me.....I can remember a couple of times when I had to technically change the discussion when I noticed some discomfort in certain students” [SL8]*

*“Sometimes the lecturers might have the interest to research more about cultural issues they would want to teach, but sometimes it’s hindered by the lack of readily available teaching resources within the university....” [SL8]*

*“....I don’t remember us doing much during our time, however, I have attended a lot of diversity courses in practice.....” [CM 2]*

*“I’m personally not an expert in cultural diversity; however they are my colleagues who are more competent to teach diversity than I am” [SL1]*

*“Of course as educators we supposed to do some research about the topic ourselves..... if the topic is a requirement..... it’s not simply enough to say we’re not taught in our training..... however, we can only teach what we are confident in” [SL3]*

*“I personally feel that as senior lecturers we are ill equipped to teach cultural sensitive topics and issues related to anti discriminatory practice in mental health” [SL9]*

*“My last nursing practice job was in the predominantly white British community practice for the last nine years and I think it could be very difficult for me to go into depth teaching*

*students about culture and diversity.....” [SL2]*

*“Yes, there is a possibility that it [cultural competence] could be left out if there are no guidelines to assist educators when designing the nursing modules” [SL6]*

*“Not sure of any guidelines” [SL5]*

*“It would be helpful if we had some sort of guidelines on what to include in the curricula” [SL8]*

*“.... Because of the few lessons we had during our second year and a few lessons conducted by external speakers on diversity, I think I have at least grasped something. ....I feel much more confident now to nurse people who’s cultural backgrounds are different from mine.....”[SN3]*

*“..... Although it was challenging during the process of learning about cultural diversity due to tensions in class, overall I found those few lessons beneficiary although not enough to say I am well prepared to be released and effectively work with cultural diverse patients.....” [SN1]*

*“ ..... to me I would say issues of culture were marginally incorporated in the curriculum just to cover the legal and professional requirements .....” [SN7]*

*“.... To say we didn’t cover issues of culture and diversity, I’ll be lying, and again to say we really covered such issues, I’ll be vague. The truth is that lessons on culture and diversity were introduced, then run over in a couple of minutes then moved on to the next topics.....” [S1FG2]*

*“..... Yes X is right, our lecturer just whitewashed issues of culture and asked us to research more without telling us whether feedback was needed from us or not.....to me it was like as long as they are covered..... from such an approach it’s difficult for me to give a definite answer to say I’m prepared from such lessons we had on cultures because I didn’t do it and nobody asked me why....” [S2FG2]*

*“ ..... from few of the lessons we had in class and some talking from the externals such as ex-patients and carers, at least I’m a bit confident of the expectations when I go into practice after summer..... ” [S3FG2]*

*“With only a few lessons centered on cultural nursing, it’s hard to say with certainty that our own training prepared us enough to nurse diverse cultural groups....” [SN1]*

*“Only now in our third year, I can remember having ex- clients and ex- carers coming to talk about their experience of the nursing care they received from the mental health staff and how they preferred to be cared... it could have been more beneficiary if we had more of these training from our first year...” [SN2]*

*“.... Because of the few lessons we had during our second year and a few lessons conducted by external speakers on diversity, I think I have at least grasped something. ....I feel much more confident now to nurse people who’s cultural backgrounds are different from mine..... ” [SN3]*

*“ .... Issues of culture are covered a lot throughout the undergraduate curriculum but not in a meaningful depth to distinguish stages of progression..... ” [SN3]*

*“ .... When discussing issues of culture in classroom environment, our lecturers always gave the same or similar examples in each and every lesson” [S3FG2]*

*“Learning the same issues every time throughout the three years becomes boring and is not helpful” [S1FG2]*

*“.....although we are including cultural competence in our current curricula, I think as nurse educators we probably need to do more than what we are doing now .....I strongly believe that integrating cross cultural education into the training of nurses may improve nurse patient interactions among the marginalized patients and there is a lot of research to support me..... ” [SL3]*

*“As lecturers, I think it’s very wrong for us try to engage ourselves into these political*

*debates where we view cultural diversity narrowly as ethnic customs and immigrant religious beliefs...” [SL8]*

*“.....definitely culture has a lot of impact on mental health, for example, in nursing, ..... the NMC requires students to provide choice to the clients.....therefore, students need to know that in order to provide greater choice and satisfaction to patients, they need to be aware of the patient’s beliefs, values and desires..... which in most cases are culturally formulated...” [SL6]*

*“Students and nurses need to know how cultures shape every aspect of the nursing process up to the extent of planning appropriate services for patients during discharge..... This reminds me of one illiterate client who was from Somali origin. As part of the discharge aftercare the nurse suggested that the social worker access funding for the client to attend local Bingos to minimize loneliness. I happen to know the local Bingo club in question which was used by predominantly White elderly people....” [SN6]*

*“.... It’s clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn’t important. If It’s that important they would give us assignment or test to assess us..... so why bother for extra burden that does not look like part of the requirements to achieve the nurse training.....” [SN4]*

*“It’s unfair when lectures give summary statements about the cultural beliefs of Africans as if Africa is a single country” [SN2]*

*“Some of our lecturers seemed to pick and choose the topics which they think will be liked by students... if topics that bring tension in class arose, the lecturers will divert to another topic...”. [SN2]*

*“It’s simply a cut on the edge [lessons on cultural nursing care], so long as if it’s covered, some aspects such as providing an interpreter are not fully discussed...” [SN3]*

*“Some lecturers try very hard, of course we don’t’ expect them to know it all in details, there are so many of them[cultures] and some of those cultures prefer the aspects of their cultures*

*to remain private to them..” [SN6]*

*“...if you go to Rome, you are expected to do what in Rome the Romans do. Why should it be that when people come to Britain, they expect the British to be experts in those foreign cultures? ... isn't this unfair and an extra burden to our society...” [SN7]*

*“..... after all why should the lecturers waste their time and our time teaching on how to provide excellent nursing care to strangers..... We didn't come to the university to learn about providing excellent nursing care to foreigners .....” [SN7]*

**Theme 2: Issues of cultural competence are incorporated in other modules although consistence and quality of training might vary from institute to institute**

*“ ..... we had lessons in sociology of health and illness where we learnt about inequalities in health in terms of class structure, ethnicity, social class, races and so on.....” [SN4]*

*“It could be a better idea if we can have modules specifically dedicated to cultural diversity like what we have in other modules” [SN3]*

*“If I were a senior lecturer, I would do more in terms of teaching the nursing care needs of diverse patients as at the moment I feel its not enough” [SN4]*

*“Some lecturers try very hard, of course we don't' expect them to know it all in details, there are so many of them[cultures] and some of those cultures prefer the aspects of their cultures to remain private to them..” [SN6]*

*“..... issues of cultural nursing care needs have been incorporated into other modules such as Sociology of Health and Illness where such issues are explored and discussed.....” [SL1]*

*“..... In one of our Domains of Nursing module, we give student scenarios of patients from different backgrounds to research on their nursing care needs and then they choose the*



*scenario and prepare it for the viva presentations.....”[SL3]*

*“ ... my previous clinical placement had patients from different ethnic, racial and cultural backgrounds and I gained a lot of skills and knowledge from them during our interactions....” [SN5].*

*“ ... we don’t have specific modules within the pre-registration mental health nurse training as issues of cultural nursing care needs have been incorporated into other modules such as Sociology of Health and Illness where such issues are explored and discussed.....” [SL1]*

*“..... you would rarely find any discussions in mental health nursing that doesn’t acknowledge the diversity of individuals [SL3].*

*“ ..... I don’t believe that there is any one course that teaches students to be cultural competence, however here we have got modules on diversity that provides insights into cultural diversity as a stepping stone towards cultural competence....”[SL3]*

*“..... You would rarely find any discussions in mental health nursing that doesn’t acknowledge the diversity of individuals” [SL3].*

*“..... In one of our Domains of Nursing module we give student scenarios of patients from different backgrounds to research on their nursing care needs and then they choose the scenario and prepare it for the viva presentation.....”[SL3]*

*“Some of our lecturers seemed to pick and choose the topics which they think will be liked by students... if topics that bring tension in class arose, the lecturers will divert to another topic...”. [SN2]*

*“It’s simply a cut on the edge [lessons on cultural nursing care], so long as if it’s covered, some aspects such as providing an interpreter are not fully discussed...” [SN3]*

*“Some lecturers try very hard, of course we don’t expect them to know it all in details, there are so many of them[cultures] and some of those cultures prefer the aspects of their cultures*

*to remain private to them...”[SN6]*

*“.....the senior lecturers at the universities need to incorporate within their core modules issues of culture and mental health nursing. They also need to teach the nursing students about culture and its impact on them and the communities they will save. For instance, if the communities they will save are mainly composed of Moslems, at least they need to teach basic Moslem mental health nursing care needs...” [CSM1]*

*“.... there is evidence from speaking to some of my students that at least they were taught about providing cultural sensitive nursing care, however, there is also a suggestion that some students were not exposed to such teaching at all ...”[CSM1]*

*“ .... There are no specificities student should be taught about cultures; however, if they can be taught about the common cultural expectations from different cultural groups, I think this will be enough. There is evidence from speaking to some of my students that at least they were taught about providing cultural sensitive nursing care, however, there is also a suggestion that some students were not exposed to such teaching at all. Probably the multicultural teaching is done; however, I don't think it's done across the board. All students need to be exposed to it. During my nurse training, I don't remember receiving such training at the University....” [CSM1]*

*“In my opinion, I think that integrating and incorporating the concepts of cross cultural nursing care into other modules already present during our teaching may be an effective way of highlighting the importance of cross cultural nursing care considerations not just as an add one extra burden but as an essential component of the holistic patient care.....”[SN1]*

*“ .....There is evidence from speaking to some of my students that at least they were taught about providing cultural sensitive nursing care, however, there is also a suggestion that some students were not exposed to such teaching at all. Probably the multicultural teaching is done; however, I don't think it's done across the board. All students need to be exposed to it. During my nurse training, I don't remember receiving such training at the University....” [CSM1]*

*“It could be a better idea if we can have modules specifically dedicated to cultural diversity like what we have in other modules” [SN3]*

*“If I were a senior lecturer, I would do more in terms of teaching the nursing care needs of diverse patients as at the moment I feel it’s not enough” [SN4]*

*“..... whilst I don’t deny the possibility that the current nursing curriculum might need to be strengthened in terms of incorporating the cultural diversity teaching, however, at the same time I don’t agree on the one size fits all approach”. [SL7]*

*“I personally disagree with those who say the curricula doesn’t address the care needs of diverse patients, the truth is that there is a lot within the curriculum about non discrimination practice from the national Service Framework of Mental Health to the NMC code practice... what I foresee as the only weakness is that currently they’re very few ways of formally assessing student competence and as a result, some student don’t take it serious” [SL4]*

*“.....although we are including cultural competence in our current curricula, I think as nurse educators we probably need to do more than what we are doing now .....” [SL3]*

**Theme 3: Discussions centred on issues of culture are perceived to promote stereotypes and prejudiced assumptions about certain cultural groups**

*“..... We didn’t come to the university to learn about providing excellent nursing care to foreigners .....” [SN7]*

*“I was upset to hear our lecturer repeatedly saying ‘White indigenous population’ as if they’re no black indigenous populations” [SN5]*

*“It’s unfair when lecturers give summary statements about the cultural beliefs of Africans as if Africa is a single country” [SN2]*

*“It gets deep into my nerves if lecturers time and again refer to Asians and Moslems when they give examples of cultures as if they’re the only cultures on earth” [SN3]*

*“.... It’s clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn’t important. If It’s that important they would give us assignment or test to assess us..... so why bother for extra burden that does not look like part of the requirements to achieve the nurse training.....” [SN4]*

*“ .....once and again such issues of racism, superiority of identity do occur.....”[SL9]*

*“..... at one time our lecturer gave an example of an Asian woman who died in a temple fire and some students began questioning why the lady didn’t run away gazing at me as if I was the one with her in the temple...’[SN3]*

*“Some of these people [ethnic minority] it’s not their choice to be here, they were forced... circumstances drove them to loose their identity, let’s not forget the days of slavery, slavery is over and let’s give them the care they deserve.....” [S3FG2]*

*“ .... Before these patients come to Britain, they were at least supposed to think of what could be the consequences when they become ill. Obviously we’re not expected to know their single cultural norms in order to be good nurses. People who want to come to England need to*

*know that they are going to England where English people speak English and nurses are not expected to learn their vernacular languages just for the case of trying to nurse them. .... in my opinion, I think issues of language barriers should not be a burden for the nurses and nursing students, but for the patients' families... that is if they wish their own relative to be treated by British Nurses ....*" [S3FG1]

*".....we didn't come here [to the university] to spent majority of our time learning about providing excellent nursing care to foreigners only ..... if we spent such a substantial amount of time learning about their needs, how much time are we supposed to spend learning about the indigenous White British people who are the majority? ....."* [S6FG2]

*"...if you go to Rome, you are expected to do what in Rome the Romans do, but why is it that that when people come to Britain, they expect the British to be experts in those foreign cultures? ..."* [SN7]

*"it's pathetic to hear that some people still feel that certain members of the British society don't belong to the British society and they have to do what in Britain the British do [responding to 'what the Romans do'] XXX needs to know that even the Caribbean is not their home, they were just dumped there..... remember they came to the plantations packed like bundles of wood in a basket..... Otherwise their mental distress is caused by their disturbed minds about their forgotten identity and roots ..... so we need to give them a thousand percent care"* [S4FG2]

*"....even some of our lecturers when they teach about diversity, you can tell that they aren't comfortable with some discussions* [SN7]

*"I think that our lecturers are actually promoting prejudice by asking us to do case studies of especially the Asian and Afro-Caribbean cultures and to come and present them in class discussion....."* [SN6]

*" .....the assumptions they teach us about certain cultural groups is not helpful at all...."* [SN1]

**Theme 4: THEME: Discussions on cultures bring issues of racism, conflict and controversy**

*“ ..... As an Asian student, every time we have lecturers that involves cultures, I hate it, .....especially when one of the lecturers mentioned that he hopes the discussion would not offend anybody again looking direct into my face as if I was the only person who got offended..... ”[s2FG1]*

*“ .... The minute I mentioned that some cultural norms that nurses are expected to respect seem to be too primitive..... , some students in class started to Bu u u u me before I finished what I wanted to say.....[SN1]*

*“... those clients from different cultural groups who came to give the talks to students made us more aware of their diverse expectations and that each is different and there is no need of knowing it all as we will ask them in practice and they will tell us.....” [S2FG1]*

*“.... It was during our second week at uni [university] when our Sociology in Health lecturer came in class and he started introducing the sociological aspects of mental health topic. The moment he mentioned that some cultures tolerate mental health differently; many students looked at me as if I was the culture being referred to .... And I felt naked..... ” [S1FG1]*

*“.... It's clear from the onset that lack of having the formal ways of assessing our knowledge to care for some cultures within our curriculum means that cultural knowledge isn't important..... ” [SN4].*

*“ ..if people can do their maths right, of course they will determine the proportion amount of time to be spent addressing diversity within the curriculum. I am not denying that people's needs should be ignored, but issues of culture have been blown out of proportion .... ” [SL4]*

*“.....If people want to base on statistics, then they I think we are doing much more in*

*terms of addressing the care needs of foreigners and other non White British people. Whether you want to say the last census gave the population of the ethnic minority to be 6% or 10%, then I think we are putting more than 10% effort in trying to address the care needs of these ethnic minority people ..... these reports such as the Bennett Inquiry they say what their authors wanted to say ....” [SL4]*

*“ .... The minute I mentioned that some cultural norms that nurses are expected to respect seem to be too primitive..... , some students in class started to Bu u u u me before I finished what I wanted to say..... Some students openly started accusing me saying do you think your own culture is a more civilised than the rest..... Some started accusing me of making some racial comments when in fact I did not make any racial comments at all..... Our class tutor who is also White just stood up and waited till the arguments were tense between Black students and White student in class. The only thing he said was that the argument was out of proportion and we need to change topics. The atmosphere in class was as if there was a civil war between Black students and White students ....” [SN1]*

*“ ..... when people start discussing about cultural care needs of patients, they tend to look at me as if I am an expert of cultures. Being born by Asian parents does not make me an expert in Asian Culture. I hate it. I hate ..... because people don’t stop it. I remember when we were talking about different approaches to death and how nurses should respond..... the moment the tutor asked about what happens with the Sikh..... , all eyes were on me as if I was a Sikh myself..... ”[S2FG1]*

*“.... We tend to draw up discussion on how the needs of patients from diverse backgrounds could be addressed, however, once in a while you will get students who feel that they are being attacked most of the time because of their cultural affiliations. At times these students would overreact and ended up bringing unsubstantiated accusation to other students. I had one student who openly accused some students of being racists and ended up accusing me of supporting students to bring racial comments. This is an area which is somehow we had to deal with although err er.er....., especially if the students are all mature students. ...” [SL2]*

*“.....I’m not quite sure but I would suggest that any lecturer who wants to introduce sensitive topics on culture and its impact on mental health nursing, I think they should possibly introduce the topic with some epidemiological data and statistics including their proper references so that listeners could see that it’s not the lecturer’s opinion data and there is no stereotyping.... In this way, possibly the students could possibly develop be open minded attitudes”. [SL5]*

**Theme 5: Education centred on cultures brings boredom in class as it appears to be irrelevant to the future**

*“.... When introducing Diversity issues module, our lecturers started by bombarding us with cultural terms that appeared to be coming from Mars and you could tell that most students were confused...” [SN6]*

*“ ....I think lecturers need to teach us only about those cultural issues we are most likely to meet in our practice, it pointless to teach us Australian Aborigines...” [SN3]*

*“start from what the students bring in the classroom environment” [SL2]*

*“.... I found the lectures to put more than enough emphasis on the British history and the British values as the best standards which other cultures should follow” [SN5].*

*“... our lecturers always claim to say whatever notes they give us is of high class in terms of knowledge about cultures, but most of the time its very confusing and beyond our understanding” [SL7]*

*“..... terms such as transcultural nursing, cultural congruent ethnocentric approaches are not helpful to us especially when introducing the topics” [SL1].*

*“they choose topics they want to teach” [SL8]*



**Theme 6: Inadequate cultural competence teaching resources and educators' lack of knowledge hinder the development of cultural competence education**

*"Sometimes the lecturers might have the interest to research more about cultural issues they would want to teach, but sometimes it's hindered by the lack of readily available teaching resources within the university....." [SL8]*

*"A substantial bit of what I teach involves a lot of consideration of the cultural needs of diverse people and you would find that our libraries are stuffed with American and Australian stuff which in most cases seemed to be irrelevant here" [SL1]*

*"There are good and bad guidelines on teaching cultural diversity, the main challenge I think lecturers face is to find good guidelines as they only appear to be few of them" [SL7]*

*".... A handful of some of those frameworks are not applicable to this country in terms of historical reasons for having them, ..... they are not always compatible with our legal and professional system..... they are good to the American and Australian systems...."[SL1]*

*".....tend to teach from an evidence based system, we need to know why in the first place those guidelines are there and where do we start ..... where do we end .....what are the signs that we have reached our intended destination....."[SL4]*

*"Of cause we have access to interlibrary loans which one can possibly use if he or she is lucky, however, such books or materials can take up to two weeks to arrive from wherever they come from, however students don't have such access and the budgets are tight..." [SL3]*

*"I have come across a peer reviewed article with inaccurate information about my own culture, and how can I use such an article as a reference or guideline to teach about cultural needs of patients who share the same background as me?" [SL6]*

*"I personally feel that as senior lecturers we are ill equipped to teach cultural sensitive*

*topics and issues related to anti discriminatory practice in mental health” [SL9].*

*“It’s not all of us who are competent to teach diversity, however, if there is need, surely we can try and find time to do a bit of research about it...” [SL2]*

*“People need to be careful on what they read and teach students, because there’s a lot of misleading and stereotypical information out there” [SL4]*

*“A substantial bit of what I teach involves a lot of consideration of the cultural needs of diverse people and you would find that our libraries are staffed with American and Australian staff which in most cases seemed to be irrelevant here” [SL1]*

*“A lot of textbooks you find in our libraries provide insufficient information that has the potential of leading us to teach stereotypical views of some cultures” [SL5]*

*“There are good and bad guidelines on teaching cultural diversity, the main challenge I think lecturers face is to find good guidelines as they only appear to be few of them” [SL7]*

*“If anyone or you can come up with good guidelines for us to use, I think it will be great and make our lives easier” [SL5]*

**Theme 7: Developing educational programs of cultural competence using educational materials and approaches that respond positively and constructively to cultural diversity**

*“As a lecturer in a culturally diverse classroom, I would prefer the university to fund the courses that will enhance my cultural sensitivity, so that I’ll be able shape the curriculum to be culturally responsive to my students” [SL1]*

*“Majority of the time the books and materials recommended by our lecturers are dominated by information that support the supremacy of the Western cultures as number one” [SN5]*

*“..... one of my classes has got more than half students who are non White and majority of them from Africa..... one way I tend to do to reduce racial tensions in class during cultural discussions is to bring statistics and references so that students don’t feel intimidated.....” [SL2]*

*“ ...To minimise such racial tensions in class, I think lecturers are supposed to make sure that the curriculum materials, textbooks and other resources used in classrooms should clearly produce meaning and define what’s appropriate in promoting social relations among diverse student groups” [SL7].*

*“.....it’s about the content and the direction of lesson that cause racial disruptions..... Once you give ground rules in your class, there is unlikely to be any racial disruptions.....” [SL3]*

*“I would introduce literature including equitable representations of diversity through the use of educational materials that are culturally sensitive to my diverse student groups” [SL9].*

*“Knowing the cultural background of my students and developing my cultural sensitivity through attending relevant professional development courses in cultural diversity will be a crucial part of teaching in the classroom” [SL6]*

*“I think students' self esteem and moral can be boosted by culturally responsive curriculum” [SL3].*

*“I think lecturers must include in their teaching,... the various positive contributions made by people from different parts of the world to this country” [CM2]*

*“The mental health nurse curriculum should include content about the cultures and contributions of many ethnic groups to the society using a variety of teaching techniques that are culturally responsive to different ethnic learning styles within the classroom environment” [CSM2]*

**Theme 8: Incorporating educational strategies that are conducive to critical reflective dialogue among diverse learners**

*“ ..... when I’m addressing issues of culture and its impact on mental health, I find it helpful to put students in let’s say two groups to research about particular topics then invite the groups to do some intergroup dialogue about their findings which I find my diverse student groups welcoming such discussions well....”[SL5]*

*“I sometimes give my students scenarios for example, one of the scenarios I gave them was of an Afro Caribbean young man who was experiencing signs of schizophrenia living with parents who were dedicated Christians..... I asked learners to identify possible causes of his illness, and possible nursing interventions ..... Obviously I would expect the students to link the attributes of somebody from an Afro Caribbean background on their discussions from assessments to interventions..... ” [SL6]*

*“In Birmingham we have got a lot of people from cultural different backgrounds. I sometimes ask my students to do case studies of a culture different from them to find more about their history, origin, faith, religion, values, food, dressing, rituals and so on..... I then ask students to come and present their findings to other students for example if one picks a Moslem culture, I would expect them to say in terms of food, Moslems would only eat Halal meat..... by so doing, the student would at least have some ideas that when they serve food to*

*Moslems, they need to be cultural sensitive to the meat they give them.....” [SL1]*

*“ ... in addition to teaching students about different cultures and how they affect the understanding of mental health and well being, I personally feel that the experiential learning we expose our students during their clinical placement is more important. ....” [SL2]*

*“... to me there is no wrong or right approach. Both experimental learning and traditional based classroom training when it comes to training students to nurse diverse people are all ok. I think each complement another....” [SL4]*

*“..... I do support the traditional based classroom teaching, however, but in nursing, some aspects cannot benefit from the classroom teaching setting, and I think cultural competence is one of them ..... therefore sending the students for clinical placement to feel how those different cultures expect the nurses to treat them I think will be more beneficiary” [SL8]*

*“ ... in addition to teaching students about different cultures and how they affect the understanding of mental health and well being, I personally feel that the experiential learning we expose our students during their clinical placement is more important. ....” [SL2]*

*“... to me there is no wrong or right approach. Both experimental learning and traditional based classroom training when it comes to training students to nurse diverse people are all ok. I think each complement another....” [SL4]*

*“..... I do support the traditional based classroom teaching, however, but in nursing, some aspects cannot benefit from the classroom teaching setting, and I think cultural competence is one of them ..... therefore sending the students for clinical placement to feel how those different cultures expect the nurses to treat them I think will be more beneficiary” [SL8]*

*“I also employ case scenarios which I find useful when it comes to transfer theory into practice” [SL5]*

*“As part of my teaching on different nursing care issues including cultural issues, I tend to use case scenarios where students will discuss appropriate responses to situations and to consider how potential cultural care needs of patients’ could be met”. [SL1]*

*“...the cultural nursing care needs of patients from diverse backgrounds can be integrated into the core curriculum by a number of ways ..... such as having case scenarios which specifically demands the knowledge and skills of diversity..... For example, one might give students case scenarios in which cultural difference acts as an obstacle to the assessment, planning and implementation of a programme of care. Such case scenarios have ability to develop a participatory decision making style on students to how issues of culture impact the whole care delivery.....” [CM2]*

*“...if you go to Rome, you are expected to do what in Rome the Romans do. Why should it be that when people come to Britain, they expect the British to be experts in those foreign cultures? ... isn't this unfair and an extra burden to our society...” [SN7]*

*“ .... Before these patients come to Britain, they were at least supposed to think of what could be the consequences when they become ill. Obviously we're not expected to know their single cultural norms in order to be good nurses. People who want to come to England need to know that they are going to England where English people speak English and nurses are not expected to learn their vernacular languages just for the case of trying to nurse them. .... in my opinion, I think issues of language barriers should not be a burden for the nurses and nursing students, but for the patients' families... that is if they wish their own relative to be treated by British Nurses ....” [S3FG2]*

*“.....we didn't come here [to the university] to spent majority of our time learning about providing excellent nursing care to foreigners only ..... if we spent such a substantial amount of time learning about their needs, how much time are we supposed to spend learning about the indigenous White British people who are the majority? .....”. [S6FG2]*

*“.....If people want to base on statistics, then they I think we are doing much more in terms of addressing the care needs of foreigners and other non White British people. Whether you want to say the last census gave the population of the ethnic minority to be 6% or 10%, then I think we are putting more than 10% effort in trying to address the care needs of these ethnic minority people ..... these reports such as the Bennett Inquiry they say what their authors wanted to say ....” [SL4]*

*“We learnt much about being culturally sensitive when interacting with community members who were involved in the delivery of the curriculum”. [SN1].*

*“..... there is no better way to develop understanding of a culture than to live within it”. [SL3].*

*“If we involve ex service user to come and deliver the lesson, we also as lecturers learn from them and devise future guidelines on what to teach based on their needs”. [SL2]*

*“We have learnt and gained as much as possible about some of the community members’ culture from the ex service users who participated in some of the lectures” [SN3]*

*“We have in the past invited nursing practitioners from diverse backgrounds to come and teach their areas of expertise and we will continue to engage cultural competence experts if our budgets allows” [SL6]*

**Theme 9: Engaging local population, service users and experts on cultural competence to assist in teaching culturally competence specific areas**

*“there is no better way to develop understanding of a culture than to live within it”. [SL3].*

*“.... having a community member and or the mental health service user, working and interacting with the students as part of the guest lecturer provides nursing students with an increased opportunity to learn more about the cultural nursing care needs of those represented.” [CSM2].*

*“I think a curriculum that has meaning in terms of addressing the needs of diverse communities has to connect and engage the support of people from those diverse cultural groups, for instance at least engaging or involving respective community leaders as they are in much more position to define some of the community needs.....” [CM1]*

*“In nursing if you’re not sure you need to ask, therefore, if our lecturers are not sure or confident of addressing some of the cultural care needs of diverse patients they also need to ask those local people to come and give us a talk” [SN5]*

*“.... there is no better way to develop understanding of a culture than to live within it”. [SL3].*

*“..... one way the university can do is to have some budget for external visiting people such as community leaders and other cultural experts to come and give a talk to students about their cultures, their expectations when members of their families are unwell, and how they preferred the nursing staff to provide nursing care to those family members. .... this is possible although might not fit well with some of the budgets.....” [CSM2]*

*“Why not invite some good spiritual leaders and pastors from the local communities, at least they can make a difference and after all they are used to teaching big crowds .....” [SN7]*

*“ ..... by inviting members of different communities to come and deliver lessons, students will be able to see how different cultures within the communities view mental health issues”[SL5].*

*“Within this university, we tend to invite a lot of ex service users’ and interested members of the community or practice nurses to come as guest lecturers and some are also responsible for identifying and providing support for lecturers when addressing issues of cultural competence within the curriculum” [SL7].*

*“..... these community members and service users are not the source of cultural competence knowledge and skills, but, rather, are partners in planning for their communities’ general needs.....”. [SL6].*

*“..... although I don’t believe that we can teach our nursing students to become cultural competence practitioners, however, I strongly believe that if we can sought out and engage such cultural experts like Dxxxxxx Sxxxxxxx [named professor and expert in cultural competence], our student could possibly gain much more than from most of the lecturers like myself who are nine out of ten not really competent in the subject.....” [SN9]*

*“..... instead of always seeking out and engaging only those with PhDs and Masters to come*



*as visiting lecturers as they used to do during our training, I would recommend if the universities can now take it as an opportunity to involve the less academic ones such as community leaders to come and address the mental health care needs of their communities. .... Community leaders hold the influence of making their followers engage or disengage with the services..... having the knowledge that nurses are also being trained by community leaders could have an impact on how services are perceived by the public.....”*  
[CSM1]

*“.... these community members and service users are not the source of cultural competence knowledge and skills, but, rather, are partners in planning for their communities’ general needs.....”* [SL6].

*“.... by inviting members of different communities to come and deliver lessons, students will be able to see how different cultures within the communities view mental health issues”*  
[SL5].

*“..... if we involve ex service user to come and deliver the lesson, we also as lecturers learn from them and devise future guidelines on what to teach based on their needs ....”* [SL2]

*“ ....when things go wrong in mental health nursing practice, the government and the public witch-hunt into the training institutions just like what happens with Stephen Lawrence and Rocky Bennett..... ”* [SL6]

*“.....we learnt much about being culturally sensitive when interacting with community members who were involved in the delivery of the curriculum..”* [SN1].

*“....we have learnt and gained as much as possible about some of the community members’ culture from the ex service users who participated in some of the lectures”* [SN3]

*“..... we do want to engage everyone who has some expertise, however sometimes it’s not that easy as people might think, we have to consider financial resources among other things...”* [SL2]

*“.... it sound quite good to invite community leaders to come and talk about their own cultural groups expectation, however, the danger is that the student might view such talks*

*from community leaders as representing their entire cultural memberships” [SL1]*

*“..... cultures are not static and I see no much benefit in engaging community leaders to be part of our team” [SL4]*

*“Although it might helpful to consult or ask senior community leaders to come and help us deliver, however, one has to realise that in practice, it might be difficult to consult those community leaders and also demands time” [SL5]*

*“..... due to our focused budgets and time it’s not always possible to invite community leaders to come and teach students about cultures in general as they’re themselves not experts in cultures in general with probably the exceptions of their own cultures.....” [SL8]*

*“..... as lecturers how do we select the appropriate and the willing members of the community to come and deliver such lectures?” [SL1]*

*“..... although it sounds a good idea to invite the community leaders, however, there is always that danger ..... that possibility that some members of the community might not appreciate the potential benefit of consultation and might not be willing to be consulted”[SL3]*

*“.... nurses must be trained at least to understand the artistic expressions of major client groups they serve” [CM2]*

*“..... we do want to engage everyone who has some expertise, however sometimes it’s not that easy as people might think, we have to consider financial resources among other things” [SL2]*

*“..... we have in the past invited nursing practitioners from diverse backgrounds to come and teach their areas of expertise and we will continue to engage cultural competence experts if our budgets allows” [SN6]*

*“..... due to our focused budgets and time it’s not always possible to invite community leaders to come and teach students about cultures in general as they’re themselves not experts in cultures in general with probably the exceptions of their own cultures.....” [SL8]*

*“I don’t think that the idea of inviting community leaders and other members of the local*

*community to come time and again to deliver cultural diversity to nursing students as a good idea especially within this university considering the current budget constraints” [SN7]*

#### **4.10: Theme 10: The need for cultural competence education that focuses on effective communication strategies**

*“.....having learnt about the histories of the Somalis in Britain helped me to contextualize their experiences .....” [SN8].*

*“ ..... we benefited a lot from Moslem religious leaders who came and gave us a lecture about how Moslems preferred to be looked after from being sick upto death and dying....” [S2FG2].*

*“....people are unique, cultures are also unique hence teaching us about major cultures in this country will only make us generalize people and stereotype them... [S2FG1].*

*“I know it’s difficult to teach us about the care needs of everyone, however, they must teach us about the basic cultural needs of the major cultural groups around us” [SN2]*

*“Of course the world has probably millions of cultures, but why not teaches us about those common ones” [S5FG2]*

*“.... if I were a lecturer, I would teach students information about specific cultures within the UK” [SN3]*

*“Birmingham is such a diverse city, however, why can’t they teach us about the major cultures and ask us to research about the rest” [S3FG2]*

*“I think I would teach learners about the major specific cultures that are mostly found on the placement settings such as Moslems, Afro Caribbean, and Sikhs and so on” [CM1]*

*“..... I would teach student about cultural diversity and how to respect the cultural*

*differences if I was one of the lecturers” [CSM1]*

*“In Birmingham we have got a lot of people from cultural different backgrounds. I sometimes ask my students to do case studies of a culture different from them to find more about their history, origin, faith, religion, values, food, dressing, rituals and so on..... I then ask students to come and present their findings to other students for example if one picks a Moslem culture, I would expect them to say in terms of food, Moslems would only eat Halal meat..... by so doing, the student would at least have some ideas that when they serve food to Moslems, they need to be cultural sensitive to the meat they give them.....” [SL1]*

*“ .....it’s a question of balancing between generic and specific cultural knowledge that we give students ..... obviously too much or too little has its consequences...” [SL5].*

*“ ..... we had lessons in sociology of health and illness where we learnt about inequalities in health in terms of class structure, ethnicity, social class, races and so on.....” [SN4]*

*“It won’t make any difference to me to teach students about specific cultures .....Even in the very unusually small cultural groups; there is great diversity among individuals” [CSM2]*

*“..... even if the lecturers decide to pick and choose let say some of the cultural groups within the UK society, still they can find themselves discriminating those minor groups that will be left out....” [S4FG2]*

*“..... as an introduction or an initial step for students to learn about cultural competence, I would say yes.... it could be helpful to teach students about specific cultures, however, it is important to be aware of the stereotypical views that students can build which could end up being towards cultural incompetence” [SL1]*

*“..... although it sounds more practical to teach students the facts about specific cultures, however, there are risks that students might take those facts and use them to stereotype their diverse client groups” [SL2]*

*“I have come across in many instances where students view a culture as a homogeneous system shared by members of the society and therefore expect it to be something that can be*

*separated and distinguished from other cultures. This is however not the case, cultures to me are quite dynamic and students need to be taught that is not the case” [SL3]*

*“I don’t agree with those who say that we should teach students about specific cultures or cultural norms. First cultures aren’t homogeneous and therefore people don’t have to make assumptions..... Secondly, they aren’t any specific cultural norms because cultures aren’t static but are very dynamic and acculturation is always influencing people’s beliefs” [SL4]*

*“..... I find it very strange and impracticable to teach students about what they perceive as the common cultures around even Birmingham. Just one individual client can have more cultural influences that might need to be addressed and that it may be impossible for any lecturer to teach about the particularities of all the different cultural groups found in Birmingham alone yet in the UK” [SL6]*

*“It won’t make any difference to me to teach students about specific cultures .....Even in the very unusually small cultural groups; there is great diversity among individuals” [CSM2]*

*“.....because cultures do not exist in isolation to the patient, therefore it’s very important for our student nurses to look at their patients holistically and that is probably one of the reasons we try to avoid teaching our students separate cultural diversity care modules.....”[SL2]*

*“..... preparing students to be cultural competent is not about teaching students about specific cultural groups which in my opinion those specific groups don’t exist” [SL7]*

*“As part of my teaching on different nursing care issues including cultural issues, I tend to use case scenarios where students will discuss appropriate responses to a situations and to consider how potential cultural care needs of patients’ could be met” [SL1]*

*“Cultural competence is an ongoing learning and acquiring of skills and specific competences about working with cultures and their acculturations and it’s not something that can be validated by being put into a specific two week course or passing an assignment or test” [SL4]*

*“ .... I don’t agree and believe that any lecturer can teach any student to become cultural*

*competent..... secondly as cultures do not exist in vacuum, therefore, cultural competent cannot be taught as a set of unchangeable facts.....cultures change with time, preferences.....societal expectations, .....even politics or the legal system of the country can force certain cultures to change their traditional habits such as arranged marriages in Western societies for example.....”[SL3]*

*“..... whilst I don’t deny the possibility that the current nursing curriculum might need to be strengthened in terms of incorporating the cultural diversity teaching, however, at the same time I don’t agree on the one size fits all approach...”. [SL7]*

*“I think the curriculum is already over stretched and that adding more courses is of no great benefit ...” [SL8]*

*“.....Individual lecturers should still have the autonomy on what to include in the curriculum and how they prefer to deliver such teaching .... Remember teaching depends on what individual lecturers find comfortable with. You once mentioned to me that during your research some lecturers felt uncomfortable to control escalating outbursts that arose from students during discussion of cultural issues. How then would you expect them to manage the situation if things are to be forced on to them.....?” [SL7]*

*“ .... Yes from the layman’s point of view it might be seen as an important thing to have specific modules on cross cultural nursing care, but, who knows, whether students will take that module as an add on extra burden to what they learn, or a separate entity which should be applied separately is something to be considered. ....” [SL6]*

*“..... students’ awareness of the benefits and our interdependence of different people from around the world would sometimes reduce those mentioned tensions and some stinginess....”[CSM2]*

*“ ..... even simply talking about different food within the UK such as curry dishes will make students feel the benefits of our cross cultural borrowings...and exposes the students to some creative talents of people from different parts of the world who are now part of our society and their talented gifts are now part of our society....”[CMS1]*

*“ ..... we have got modules on diversity that provides insights into cultural diversity as a stepping stone towards cultural competence ....”[SL3]*

**Theme 11: The need for cultural competence education that focuses on effective cultural sensitive skills**

*“..... We had sessions on effective communication skills and language needs where we were given assignments to reflect on or interpersonal relationships with clients whose first language was not English....” [SN7]*

*“ ....we thoroughly discussed and critically examined the use of interpreters .....” [SN2]*

*“I would say in each and every module studied, students are taught the different skills of communicating with different patient groups which includes the deaf, those whose first language is not English or where clashes of accent co exist...” [SL8]*

*“ ..... we encourage and give students the opportunity to work with named clients so that they build a therapeutic relationship by sharing some personal information with that particular client ... and this will also facilitate some trust” [CM2].*

*“I think communication is one of the important care needs of patients from different cultural backgrounds and we would like more of those sessions” [SN2]*

*“I have come across many of my students who are very good communicators but when it comes to work with clients, they cannot develop proper rapport with clients... I think this is a skill which probably needs to be addressed within the classroom setting by their lecturers” [CM1]*

*“I sometimes ask students from different backgrounds to come and role play the nurse-patient interaction which I believe is one of the ways we train our students some skills of cultural competence” [SL5]*

*“As nurses we need to carefully listen to the accents of the patients and we also need to talk slowly and loudly especially if we have got different accent from them” [SN3]*

*“Some of our clients came from far places such as Kosovo and without any clinical history at all ..... Some student nurses tend to struggle when it comes to client history taking; therefore I think it might be helpful if their training also prepares them more when it comes to interviewing clients especially for the first time. ...” [CM1]*

*“Some clients just want to be listened to so nurses should have skills of good listening without interruptions” [S1FG2]*

*“Quite a number of students tend to struggle in terms of demonstrating in their assignments on how they provided patient centred care to their clients” [SL5]*

*“..... some cultures, if interrupted when they are talking during interviewing them, they become upset or aggressive, therefore you need to listen to them attentively” [S3FG2]*

*“Mental health nurses need to be trained on how to negotiate with the clients during care planning, implementation reviewing ...” [CM2]*

*“It is important that we equip student nurses with the skills of discussing any treatment plans with the clients and then negotiate the plans of care with clients and their families or carers” [SL8]*

*“I have come across some third year mental health nurses who aren’t aware that the care plans should be a result of a partnership in decision making between the nurse and the patient” [CSM1]*

*“ ... my previous clinical placement had patients from different ethnic, racial and cultural backgrounds and I gained a lot of skills and knowledge from them during our interactions....” [SN5].*



*“Some of the patients when they develop mental health problems, they will lose their ability to speak in English and therefore would need interpreters” [SN1]*

*“One of the issues we tend to focus on when teaching students to nurse diverse patient groups is to be patient focused rather than focussing on the patient’s cultural background..... If the students put their focus on the client’s needs, then automatically the issues of culture will emerge automatically and they can take on board holistically and not in isolation..... However, if the student put more emphasis on the patient’s culture, the nursing care outcome is mostly likely to be influenced by cultural prejudices... .”[SL5]*

*“... lecturers are different and each one is free to have their own approaches. My own approach when addressing the nursing care needs of diverse patients is by using the patient centred focus approach. By using the patient focus I will be able to teach my students ways of viewing the patient as a whole rather than their cultural backgrounds or their illnesses. By taking such a holistic view of the patient, then automatically the patient is empowered to discuss their own illnesses as they experience them..... obviously in turn, the patient would be able to give a clues to the nurses about their cultural beliefs and how such cultural beliefs influences or have an impact on their health”[SL5]*

*“No matter whatever cultural background the patient comes from, the patient must be the judge to their own care..... Within the curricula, I think students need to be taught different ways of empowering patients to negotiate and decide their own nursing care.....” [CSM1]*

*“..... quite a number of students tend to struggle in terms of demonstrating in their assignments on how they provided patient centred care to their clients” [SL1]*

*“..... I think lecturers have to step their efforts and try to teach students better skills of providing holistic patient centred care to their clients. To me each patient is diverse and has his or her own worldviews about a particular condition or illness and such world views could be influenced by their social environment or religious beliefs.....” [CM2]*

*“..... when planning and implementing any nursing interventions, students are supposed to*

*know that the centre of the focus is the patient and their immediate family.....this is because the patient and their family are in a better position to identify and understand their cultural beliefs and influences that affect their mental health and recovery.....” [CSM2]*

*“.... From working with nursing students in a cultural diverse place like H\*\*\*\*\*, to me patient centred care is the key to cultural sensitive care, hence strategies to teaching patient centred care must be a must in the curriculum if students are to be equipped with cultural sensitive nursing care skills.....” [CM1]*

*“ ..... It’s not enough to say students will be clinically culturally competent after giving them some information, lectures and other classroom based activities ..... They also need to be exposed into the clinical settings where they get the opportunity to work with people from all backgrounds.. the dominant and the minorities backgrounds ....” [SL3]*

*“..... direct and meaningful experiences of students with clients from different cultural backgrounds will help them understand diverse health care needs of people.....” [CM1]*

*“ ..... the racial tensions you suggested to me that they are reported to be happening among students, suggests to me that student nurses don’t understand themselves ..... in order for students to understand themselves I think they need to interact with other people different from them. ... I think the best people to interact with first are for them to go to placements where they have the opportunity to freely interact with different clients from different backgrounds.....” [CM2]*

*“ .... In clinical placements students will have the chance to interact with patients from different backgrounds under the supervision and support of their mentors and will thereby gain confidence when they graduate ..... as they will be working alone with unfamiliar cultures.....” [CM1]*

## **Theme 12: Promoting cultural awareness by examining and reflecting on one's cultural background**

*“.... one of the strategies I tend to use when addressing issues of culture in class is to ask students to consider their own cultural backgrounds and practices before attempting to teach them about other cultures [SL5]*

*“..... I find it better to start by giving students some work whereby they write about their individual and family cultural values, practices and beliefs before the lesson, then come the lesson, I would ask them to bring their anonymous pieces of work forward so that we can read for the whole class. By that I find that students would be able to see where their cultural values differ and are similar to other people” [SL1]*

*“I particularly teach my students to be able to move from being culturally aware of their own heritage to becoming culturally aware of the heritage of others” [SL2]*

*“.... I think one way to tackle the issue of culture within the university setting is to encourage students to reflect and examine their own cultural values and beliefs first in order to appreciate the cultural values and beliefs of others”[CM1]*

*“..... if people are able to reflect on their personal values and biases, obviously they will be able to understand and appreciate other people's cultural values and beliefs which are different from them” [SL6]*

*“ . some of the mentioned tensions could be reduced if students are encouraged to express their own individual personal values and beliefs first in order to appreciate other people's values and beliefs” [SL7]*

*“..... if students are equipped with the skills of self awareness, they will be able to understand and appreciate the cultural differences and similarities that exist within, among and between groups” [SL8]*

*“I was upset to hear our lecturer repeatedly saying “White indigenous population” as if they’re no black indigenous populations” [SN5]*

*“..... it’s unfair when lectures give summary statements about the cultural beliefs of Africans as if Africa is a single country” [SN2]*

*“It gets deep into my nerves if lecturers time and again refer to Asians and Moslems when they give examples of cultures as if they’re the only cultures on earth” [SN3]*

*“..... whilst it’s the right thing to encourage students to reflect on their self, it is equally true for educators to reflect on their own personal biases about some cultures .....” [SL3]*

*“..... if people are able to reflect on their personal values and biases, obviously they will be able to understand and appreciate other people’s cultural values and beliefs which are different from them” [SL6]*

**Theme 13: Promote open discussions on privileged and marginalised groups when addressing issues of cultural competence**

*“Nine out of ten you find that students are sited according to their cultural pockets which makes it harder at times for students to cross share their cultural heritage” [SL8]*

*“..... when I brought in and presented some statistics and materials about certain culture you could tell that some students felt as if their cultures are being attacked....” [SL8]*

*“.....at one time I asked students to tick their cultural background in terms of ethnicity and there were some White students who ticked to say that they had no ethnicity or culture” [SL3]*

*“..... many text books have for decades now talked about the inequalities in health and the impact such inequalities have on minority patients and I don’t think this could be the solution.....I think educators should start openly and explicitly discuss with their students the advantages that majority White people enjoy in society rather than solely focusing their discussions on the disadvantages faced by minority groups in this country .....” [SL9]*

*“.... what is important as a lecturer is to be able to deal with such tensions effectively. One way I will deal with such tensions myself is possibly to approach cultural awareness programs from both the advantages of the privileges enjoyed by White dominant groups and the disadvantages suffered by ethnic minority groups. By so doing, perhaps the privileged dominant members of the group might appreciate other people’s disadvantages and may avoid negative attitudes to them”. [SL3]*

*“.... well, time and again as a mental health lecturer you should expect to find some tensions among diverse groups of students during discussions centered on cultural diversity due to student cultural uniqueness. What is important as a lecturer is to be able to deal with such tensions effectively. One way I will deal with such tensions myself is possibly to approach cultural awareness programs from both the advantages of the privileges enjoyed by White dominant groups and the disadvantages suffered by ethnic minority groups. By so doing, perhaps the privileged dominant members of the group might appreciate other people’s disadvantages and may avoid negative attitudes to them”. [SL3]*

*“.... of course we can try to openly address issues of White privileges and the disadvantages faced by some racial minority groups in this country when teaching cultural competence, however, they are possible dangers that we might over-generalise or reinforce stereotypes about particular cultural groups considering issues of Al-Qaeda and its links to some cultural groups...” [SL4].*

*“Some of these people [ethnic minority] it’s not their choice to be here, they were forced... circumstances drove them to loose their identity, let’s not forget the days of slavery, slavery is over and let’s give them the care they deserve.....” [S3FG2]*

*“ .... Before these patients come to Britain, they were at least supposed to think of what could*

*be the consequences when they become ill. Obviously we're not expected to know their single cultural norms in order to be good nurses. People who want to come to England need to know that they are going to England where English people speak English and nurses are not expected to learn their vernacular languages just for the case of trying to nurse them. .... in my opinion, I think issues of language barriers should not be a burden for the nurses and nursing students, but for the patients' families... that is if they wish their own relative to be treated by British Nurses ...." [S3FG1]*

*"...if you go to Rome, you are expected to do what in Rome the Romans do, but why is it that that when people come to Britain, they expect the British to be experts in those foreign cultures? ..." [SN7]*

## **Appendix 12: University of Wolverhampton Sub Research Ethics Committee Approval Letter**

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